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No. 02-1667

# In the Supreme Court of the United States

STATE OF TENNESSEE, PETITIONER

*v.*

GEORGE LANE, ET AL.

*ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT*

## APPENDIX TO THE BRIEF FOR THE UNITED STATES

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## APPENDIX A

**Cases Evidencing Unconstitutional Treatment of Individuals with Disabilities:**

*Foucha* v. *Louisiana*, 504 U.S. 71 (1992) (Louisiana statute allowing continued confinement of the mentally ill, who were acquitted of crimes by reason of insanity, resulted in unconstitutional confinement, in violation of the Due Process Clause, where the hospital review committee had reported no evidence of mental illness and recommended conditional discharge); *City of Cleburne* v. *Cleburne Living Ctr.*, 473 U.S. 432 (1985) (unconstitutional zoning discrimination); *Youngberg* v. *Romeo*, 457 U.S. 307, 315, 322 (1982) (institutionalized persons have due process "right to adequate food, shelter, clothing, and medical care," "safe conditions," and freedom from unreasonable physical restraint, as well as to "such training as may be reasonable in light of [the resident's] liberty interests in safety and freedom from unreasonable restraints"); *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975) (unconstitutional confinement); *Delano-Pyle* v. *Victoria County*, 302 F.3d 567, 575-576 (5th Cir. 2002) (affirming a jury verdict that included evidence of a police officer giving a sobriety test and *Miranda* warnings to a deaf plaintiff who could not understand him, and then arresting the plaintiff), cert. denied, No. 02-1223, 2003 WL 545392 (Oct. 6, 2003); *Kiman* v. *New Hampshire Dep't of Corrs.*, 301 F.3d 13, 15-16 (1st Cir. 2002) (disabled inmate stated Eighth Amendment claims for denial of accommodations needed to protect his health and safety due to his degenerative nerve disease), aff'd by an equally divided court, 332 F.3d 29 (2003) (en banc); *MX Group, Inc.* v. *City of Covington*, 293 F.3d 326, 345 (6th Cir. 2002) ("blanket prohibition of all metha-

done clinics from the entire city is discriminatory on its face"); *Popovich* v. *Cuyahoga County Ct. of Common Pleas*, 276 F.3d 808 (6th Cir.) (en banc) (deaf parent denied communication assistance in child custody proceeding), cert. denied, 537 U.S. 812 (2002); *Armstrong* v. *Davis*, 275 F.3d 849 (9th Cir. 2001) (failure to conduct parole and parole revocation proceedings in a manner that disabled inmates can understand and in which they can participate), cert. denied, 537 U.S. 812 (2002); *Baird* v. *Rose*, 192 F.3d 462 (4th Cir. 1999) (seventh-grader suffering from clinical depression prohibited from singing in school choir); *Key* v. *Grayson*, 179 F.3d 996 (6th Cir. 1999) (deaf inmate denied access to sex offender program required as precondition for parole), cert. denied, 528 U.S. 1120 (2000); *Bradley* v. *Puckett*, 157 F.3d 1022, 1025-1026 (5th Cir. 1998) (failure for several months to provide means for amputee inmate to bathe led to infection); *Gorman* v. *Easley*, 257 F.3d 738, 742 (8th Cir. 2001) (paraplegic arrested for trespass improperly restrained in non-wheelchair-accessible police van, causing his urine bag to burst, "soaking him with his own urine" and resulting in serious medical problems), judgment rev'd in part on grounds not relevant, 536 U.S. 181 (2002); *Layton* v. *Elder*, 143 F.3d 469, 470-472 (8th Cir. 1998) (mobility-impaired veterans' exclusion from a session of county quorum court and from courtroom due to their inability to access the second floor of the county courthouse); *Innovative Health Sys., Inc.* v. *City of White Plains*, 117 F.3d 37, 49 (2d Cir. 1997) (building permit denied for drug and alcohol treatment center "based on stereotypes and unsupported fears"); *Love* v. *Westville Corr. Ctr.*, 103 F.3d 558, 558, 560-561 (7th Cir. 1996) (quadriplegic inmate "was unable to participate in substance abuse, education, church, work, or transition pro-



grams available to members of the general inmate population" due to "intentional discrimination"); *Koehl* v. *Dalsheim*, 85 F.3d 86 (2d Cir. 1996) (Eighth Amendment violated when inmate with serious vision problem denied glasses and treatment); *Weeks* v. *Chaboudy*, 984 F.2d 185, 187 (6th Cir. 1993) ("squalor in which [prisoner] was forced to live as a result of being denied a wheelchair" violated the Eighth Amendment); *Thomas S.* v. *Flaherty*, 902 F.2d 250 (4th Cir.) (unconstitutional confinement when appropriate community placement available), cert. denied, 498 U.S. 951 (1990); *Leach* v. *Shelby County Sheriff*, 891 F.2d 1241, 1243-1244 (6th Cir. 1989) (finding a policy or custom of deliberate indifference to serious medical needs of paraplegic inmates; evidence showed that, "[d]espite his medical need for cleanliness, [an inmate] was not bathed for several days," "was forced to remain for long periods of time in his own urine due to inadequate catheter supplies and was given inadequate aid for his bowel training needs despite his repeated requests for help"), cert. denied, 495 U.S. 932 (1990); *Chalk* v. *United States Dist. Ct. Cent. Dist. of Cal.*, 840 F.2d 701 (9th Cir. 1988) (certified teacher barred from teaching after diagnosis of AIDS); *LaFaut* v. *Smith*, 834 F.2d 389 (4th Cir. 1987) (Powell, J.) (failure to provide paraplegic inmate with an accessible toilet is cruel and unusual punishment); *Parrish* v. *Johnson*, 800 F.2d 600, 603, 605 (6th Cir. 1986) (prison guard repeatedly assaulted paraplegic inmates with a knife, forced them to sit in their own feces, and taunted them with remarks like "crippled bastard" and "[you] should be dead"); *Clark* v. *Cohen*, 794 F.2d 79 (3d Cir.) (unconstitutional confinement), cert. denied, 479 U.S. 962 (1986); *Miranda* v. *Munoz*, 770 F.2d 255, 259 (1st Cir. 1985) (failure to provide medications for epilepsy, which caused prisoner's death,

violated Eighth Amendment); *Lynch* v. *Baxley*, 744 F.2d 1452 (11th Cir. 1984) (State subjected individuals awaiting civil commitment proceedings to unconstitutional conditions of confinement in county jails); *Pomerantz* v. *Los Angeles County*, 674 F.2d 1288, 1289 (9th Cir. 1982) ("undisputed facts show that the Los Angeles County Jury Commissioner, and other employees directly involved in the jury selection process for the Superior Court for the County of Los Angeles had, prior to January 1, 1978, excluded all blind persons from jury service solely because they were blind"); *Pushkin* v. *Regents of Univ. of Colo.*, 658 F.2d 1372 (10th Cir. 1981) (doctor with multiple sclerosis unconstitutionally denied residency out of concern about patients' reactions); *Ferrell* v. *Estelle*, 568 F.2d 1128, 1133 (5th Cir.) (deaf habeas petitioner's "rights were reduced below the constitutional minimum" because he could not understand his trial), withdrawn due to death of petitioner, 573 F.2d 867 (1978); *Gurmankin* v. *Costanzo*, 556 F.2d 184 (3d Cir. 1977) (holding unconstitutional an irrebuttable presumption that blind teacher cannot instruct sighted students); *Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974) (unconstitutional conditions of confinement for the mentally ill); *Pathways Psychosocial* v. *Town of Leonardtown*, 133 F. Supp. 2d 772, 791-792 (D. Md. 2001) (denying summary judgment for defendants on claim that town officials violated Equal Protection Clause through zoning decisions that excluded a home for individuals with mental retardation), after judgment, 223 F. Supp. 2d 699, 704-705 (2002) (jury found constitutional violation, and motion for new trial was denied); *McCray* v. *City of Dothan*, 169 F. Supp. 2d 1260, 1279-1280 (M.D. Ala. 2001) (police officer had "not articulated *any* specific facts upon which suspicion reasonably could be founded" other than "the communication gap between a deaf man and herself"), aff'd in part & rev'd in part, No. 01-15756, 2003 WL 21067092 (11th Cir. Apr. 24, 2003) (Table); *M.H.* v. *Bristol Bd. of Educ.*, 169 F. Supp. 2d 21, 24-25 (D. Conn. 2001) (possible substantive due process violation where school employees spat water in disabled student's face and restrained him so forcibly as to result in bruising); *Doe* v. *Rowe*, 156 F. Supp. 2d 35 (D. Me. 2001) (unconstitutional restriction on voting by those with mental disabilities); *Project Life, Inc.* v. *Glendening*, 139 F. Supp. 2d 703, 705 (D. Md. 2001) (unlawful rejection of permit for drug treatment facility based on "community prejudices"), aff'd, No. 01-1754, 2002 WL 2012545 (4th Cir. Sept. 4, 2002); *Salcido ex rel. Gilliland* v. *Woodbury County*, 119 F. Supp. 2d 900, 931 (N.D. Iowa 2000) (granting summary judgment for mentally ill plaintiff on claim that he was denied due process by State's denial of an appropriate institutional placement without notice or hearing); *New York* v. *County of Schoharie*, 82 F. Supp. 2d 19 (N.D.N.Y. 2000) (inaccessible polling places); *New York* v. *County of Delaware*, 82 F. Supp. 2d 12 (N.D.N.Y. 2000) (inaccessible polling places); *Schmidt* v. *Odell*, 64 F. Supp. 2d 1014 (D. Kan. 1999) (amputee forced to crawl around jail, resulting in injury and infection, in violation of Eighth Amendment); *Matthews* v. *Jefferson*, 29 F. Supp. 2d 525 (W.D. Ark. 1998) (paraplegic litigant had to be carried up stairs to court room for all-day hearing at which he could not leave to get food or use the restroom to empty catheter, resulting in infection; eventually had to crawl down steps to get out after everyone left the courthouse without him); *Hanson* v. *Sangamon County Sheriff's Dep't*, 991 F. Supp. 1059, 1061-1062 (C.D. Ill. 1998) (possible constitutional violation where deaf arrestee was denied the opportunity to post bond and make a telephone call because

the police department failed to provide, despite his requests, alternatives to the conventional telephone, and that denial resulted in much longer detention than other, similarly situated arrestees); *Lewis* v. *Truitt*, 960 F. Supp. 175 (S.D. Ind. 1997) (Fourth Amendment prohibits use of force against an individual, whom officers know to be deaf, for not complying with officers' spoken commands); *Carty* v. *Farrelly*, 957 F. Supp. 727, 739 (D.V.I. 1997) ("The abominable treatment of the mentally ill inmates shows overwhelmingly that defendants subject inmates to dehumanizing conditions punishable under the Eighth Amendment."); *Kaufman* v. *Carter*, 952 F. Supp. 520 (W.D. Mich. 1996) (amputee hospitalized after fall in inaccessible jail shower); *Bullock* v. *Gomez*, 929 F. Supp. 1299, 1301, 1307 (C.D. Cal. 1996) (possible constitutional violation where California Department of Corrections' family visiting program precluded HIV-positive inmates from having the same overnight visits with spouses afforded other inmates, even where spouse was also HIV positive and incapable of bearing children); *Clarkson* v. *Coughlin*, 898 F. Supp. 1019, 1049 (S.D.N.Y. 1995) (holding, *inter alia*, that state prison officials' failure to provide interpreters or other assistive services to deaf and hearing impaired inmates during medical treatment violated the Eighth Amendment, as at least two such inmates experienced improper and possibly harmful treatment through provision of medical treatment in absence of qualified interpreters); *Stillwell* v. *Kansas City, Mo. Bd. of Police Comm'rs*, 872 F. Supp. 682, 688 (W.D. Mo. 1995) (holding that the Board of Police Commissioners' licensing scheme violates the Due Process Clause of the Fourteenth Amendment because it irrebuttably presumes that an individual with only one hand is unqualified for the position of armed security guard); *Harrelson* v.



*Elmore County*, 859 F. Supp. 1465, 1466 (M.D. Ala. 1994) (paraplegic prisoner denied use of a wheelchair and forced to crawl around his cell); *Eric L.* v. *Bird*, 848 F. Supp. 303, 306, 308 (D.N.H. 1994) (possible constitutional violation where children with disabilities in foster care alleged that the State failed "to take the required measures to maintain the integrity of plaintiffs' families where possible, to reunite removed children with their families as soon as possible, or to place them in secure, permanent homes within an appropriate time and in an appropriate manner," as well as failed "to provide services necessary to protect children in the class from harm"); *T.E.P.* v. *Leavitt*, 840 F. Supp. 110 (D. Utah 1993) (statute prohibiting and voiding marriages between individuals with AIDS); *Noland* v. *Wheatley*, 835 F. Supp. 476, 480-482 (N.D. Ind. 1993) (possible constitutional violation where semi-quadriplegic inmate confined to a wheelchair was confined to secluded padded cell for months, denied sufficient water to maintain kidney functioning or to permit sanitary handling of colostomy and urostomy bag, forcing him to "eat many meals with the human waste still on his hands," and was unable to sleep in bed because his wheelchair could not fit through the doorway, all resulting in adverse medical conditions); *Casey* v. *Lewis*, 834 F. Supp. 1569, 1582-1583 (D. Ariz. 1993) (holding that prison's failure to provide accessible bathrooms, showers, and cells to mobility-impaired inmates, as well as a consistent pattern of delays in prisoner receipt of hearing aids, violated the Eighth Amendment); *Galloway* v. *Superior Court*, 816 F. Supp. 12 (D.D.C. 1993) (blind individuals categorically excluded from jury service); *United States* v. *Borough of Audubon*, 797 F. Supp. 353, 360 (D.N.J. 1991) (predominant motivation underlying city's efforts to exclude group home

for the handicapped "was discriminatory animus"), aff'd, 968 F.2d 14 (3d Cir. 1992) (Table); *Nolley* v. *County of Erie*, 776 F. Supp. 715 (W.D.N.Y. 1991) (Constitution violated where inmate with HIV was housed in the part of a prison reserved for inmates who are mentally disturbed, suicidal, or a danger to themselves, and was denied access to prison library and religious services); *Kroll* v. *St. Charles County*, 766 F. Supp. 744, 744-751 (E.D. Mo. 1991) (courthouse and government buildings broadly inaccessible to individuals with mobility impairments); *Bonner* v. *Arizona Dep't of Corrs.*, 714 F. Supp. 420 (D. Az. 1989) (deaf, mute, and vision-impaired inmate denied communication assistance, including during disciplinary proceedings, counseling sessions, and medical treatment); *DeLong* v. *Brumbaugh*, 703 F. Supp. 399, 405 (W.D. Pa. 1989) (decision to exclude deaf individual from jury was "unreasonable, discriminatory and violative of Section 504 of the Rehabilitation Act"); *Doe* v. *Dolton Elem. Sch. Dist.*, 694 F. Supp. 440 (N.D. Ill. 1988) (elementary student with AIDS excluded from attending regular classes or extracurricular activities); *Robertson* v. *Granite City Comm. Unit Sch. Dist.*, 684 F. Supp. 1002 (S.D. Ill. 1988) (seven-year old student with AIDS confined to a modular classroom where he was the only student); *Thomas* v. *Atascadero Unified Sch. Dist.*, 662 F. Supp. 376 (C.D. Cal. 1986) (kindergarten student with AIDS excluded from class and forced to take home tutoring); *Thompson* v. *City of Portland*, 620 F. Supp. 482, 485-487 (D. Me. 1985) (police violated the constitutional rights of a blind diabetic who was in insulin shock by arresting him, transporting him on floor of police cruiser, jailing him, and ignoring his explanation that he was in insulin shock, despite fact that he wore a Medic-Alert necklace and carried a white cane); *Ass'n for*



*Retarded Citizens of N.D.* v. *Olson*, 561 F. Supp. 473, 491-492 (D.N.D. 1982) (finding violations of mentally retarded residents' constitutional rights to privacy, private property, and free association, as (1) many of the mentally retarded residents "are left fully naked in front of each other and assistants and such residents are not provided places where they can be in private" and "are denied the opportunity to decide for themselves how to dress"; (2) the State did not "adequately provide for an accounting of [each] resident's personal property and for a safe place of storage"; and (3) the State did not "provide residents who are capable of communicating, reasonable opportunities to communicate with others both inside and outside the institution where they reside"), aff'd, 713 F.2d 1384 (8th Cir. 1983); *Garrity* v. *Gallen*, 522 F. Supp. 171, 214 (D.N.H. 1981) ("blanket discrimination against the handicapped * * * is unfortunately firmly rooted in the history of our country"); *New York State Ass'n for Retarded Children, Inc.* v. *Carey*, 466 F. Supp. 487 (E.D.N.Y. 1979) (mentally retarded students excluded from public school system); *Hairston* v. *Drosnick*, 423 F. Supp. 180 (S.D. W. Va. 1976) (school refused to admit child with spina bifida without the daily presence of her mother, even though student was of normal mental competence and capable of performing easily in a classroom situation); *Smith* v. *Fletcher*, 393 F. Supp. 1366, 1368 (S.D. Tex. 1975) (government assigned paraplegic, who had a Master's degree in physiology, to menial clerical tasks based on "arbitrary and unfounded decision as to her physical capabilities"), aff'd as modified, 559 F.2d 1014 (5th Cir. 1977); *Mills* v. *Board of Educ.*, 348 F. Supp. 866 (D.D.C. 1972) (mentally retarded students excluded from public school system); *Pennsylvania Ass'n for Retarded Children* v. *Commonwealth*, 334 F. Supp.

1257 (E.D. Pa. 1971) (mentally retarded students excluded from public school system); *Daly* v. *DelPonte*, 624 A.2d 876, 880, 885 (Conn. 1993) (holding that the commissioner's exercise of his "statutory authority to condition a motor vehicle operator's license on the licensee's reporting his or her medical status" violated the state constitution's equal protection provision because the record "contained no evidence that th[e] reporting requirement was narrowly tailored either to the plaintiff's condition at the time of its issuance or to his probable future condition for the designated time period"); *State* v. *Schaim*, 600 N.E.2d 661, 672 (Ohio 1992) (under the Confrontation Clause, "[a] defendant who cannot hear is analogous to a defendant who cannot understand English, and a severely hearing-impaired defendant cannot be tried without adopting reasonable measures to accommodate his or her disability"); *Moye* v. *Moye*, 627 P.2d 799, 801 (Idaho 1981) (holding that, while a parent's physical condition is a valid consideration in the "best interests" approach to determining the issue of a child's custody, the trial court's overemphasis on the mother's epilepsy rendered the custody award to the father an abuse of discretion); *State* v. *Staples*, 437 A.2d 266, 268 (N.H. 1981) (ineffective assistance of counsel in failing to secure assistance for hearing-impaired defendant whose disability made him "unable to assist effectively in the preparation of his defense"); *In re Marriage of Carney*, 598 P.2d 36, 42 (Cal. 1979) (lower court "stereotype[d] William as a person deemed forever unable to be a good parent simply because he is physically handicapped"); *Connecticut Inst. for the Blind* v. *Connecticut Comm'n on Human Rights & Opps.*, 405 A.2d 618, 621 (Conn. 1978) (blanket exclusion from state jobs of persons with visual impairments); *State* v. *Board of Educ.*, 172 N.W. 153, 153



(Wis. 1919) (excluding a boy with cerebral palsy from public school because he "produces a depressing and nauseating effect upon the teachers and school children"); *State* v. *Barber*, 617 So. 2d 974, 976 (La. Ct. App. 1993) ("[T]he Constitution requires that a defendant sufficiently understand the proceedings against him to be able to assist in his own defense. Clearly, a defendant who has a severe hearing impairment, without an interpreter, cannot understand the testimony of witnesses against him so as to be able to assist in his own defense."); *People* v. *Green*, 561 N.Y.S.2d 130, 133 (County Ct. 1990) (holding that prosecutor's peremptorily striking a juror solely because she was hearing impaired, and not because of any doubt of the juror's ability to communicate, violated the juror's right to equal protection); *Stewart* v. *Stewart*, 521 N.E.2d 956, 965-966 (Ind. Ct. App. 1988) (holding that father's visitation rights were improperly terminated because of evidence that he was infected with the AIDS virus); *Peeler* v. *State*, 750 S.W.2d 687, 690-691 (Mo. Ct. App. 1988) (constitutionally ineffective assistance of counsel in failure to request an interpreter, where the hearing-impaired defendant was "probably unable to understand what was being said at trial"); *District 27 Comm. Sch. Bd.* v. *Board of Educ.*, 502 N.Y.S.2d 325 (Sup. Ct. 1986) (two school boards sought to prevent attendance of any student with AIDS in any school in the city, unless all of the students at that school had AIDS); *Bednarski* v. *Bednarski*, 366 N.W.2d 69, 73 (Mich. Ct. App. 1985) (holding that a mother's deafness was inappropriately weighed against her in a custody dispute over her two minor children); *People* v. *Rivera*, 480 N.Y.S.2d 426, 434 (Sup. Ct. 1984) (conviction was unconstitutionally obtained because the deaf defendant had no interpreter and did not understand his trial); *In re*

*Marriage of Paula R.*, 102 Cal. App. 3d 981, 988-989 (Ct. App. 1980) (reversing the trial court's award of permanent custody of child to father because mother was confined to a wheelchair, as the trial court did not use the proper standard in determining who should receive custody: "whether the handicapped parent's condition will in fact have a substantial and lasting adverse effect on the best interests of the child"); *Bevan* v. *New York State Teachers' Retirement Sys.*, 345 N.Y.S.2d 921 (Sup. Ct. 1973) (statute allowing forced retirement of teacher who became blind), modified, 355 N.Y.S.2d 185 (App. Div. 1974); *In re Adoption of Richardson*, 251 Cal. App. 2d 222, 239 (1967) (trial court "stated, in effect, he will systematically strike any and all deaf-mute petitioners from any list of prospective adopting parents"); *Commonwealth* v. *Smith*, 119 A.2d 620, 622 (Pa. Super. Ct. 1956) (holding that the fact that a father suing for custody of his son suffers from epilepsy is a factor that should be considered in determining whether to award custody).

## APPENDIX B

The Justice Department publishes quarterly status reports, which include information from a sampling of the Department's Disabilities Act enforcement efforts under 42 U.S.C. 12133. The status reports can be found at http://www.ada.gov/enforce. htm. The 34 reports published to date list 110 matters concerning courthouse accessibility or effective access to judicial proceedings. The following is a list of those matters. One case (against the State of Massachusetts alleging problems with physical accessibility) resulted in a lawsuit (that remains pending), which was reported in the January 2003 status report. The Table includes the jurisdiction in which the courthouses are located, the type of problem reported by persons with disabilities, and the date of the status report in which the matter appears. There are 50 cases that resulted in formal settlement agreements, 51 cases that resulted in informal settlement agreements, and 8 cases that resulted in formal mediation. In cases resulting in informal settlements or mediation, the Justice Department does not identify the covered jurisdiction by name:

**Complaints Resulting In Formal Settlement Agreements:**

| *Jurisdiction* | *Type of Problem* | *Status Report* |
|---|---|---|
| Lucas County, OH | physical access | Jan. - Mar. 2003 |
| Guernsey County, OH | physical access | Oct. - Dec. 2002 |
| Essex County, NJ | physical access | Oct. - Dec. 2002 |
| Windsor County, VT | lack of sign language interpreter | Oct. - Dec. 2002 |
| Warren, OH | physical access | Apr. - June 2002 |
| Ben Hill County, GA | physical access | Apr. - June 2001 |
| Gulfport, MS | lack of sign language interpreter | Apr. - June 2000 |

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|---|---|---|
| Shelby County, TN | lack of assistive listening devices | Apr. - June 2000 |
| Adair County, OK | physical access | Jan. - Mar. 2000 |
| Houston, TX | lack of assistive listening devices | Jan. - Mar. 2000 |
| Toledo, OH | physical access and lack of communication assistance | July - Sep. 1999 |
| Lake County, IL | lack of sign language interpreter | July - Sep. 1999 |
| Oklahoma County, OK | physical access and lack of communication assistance | Apr. - June 1999 |
| Georgiana, AL | physical access | Apr. - June 1999 |
| State of Hawaii | lack of sign language interpreter and assistive listening devices | Oct. - Dec. 1998 |
| McDowell County, WV | physical access | July - Sep. 1998 |
| Mendocino County, CA | physical access | July - Sep. 1998 |
| Johnson County, TN | physical access | July - Sep. 1998 |
| Citrus County, FL | physical access | Apr. - June 1998 |
| Chico County, AR | physical access | Jan. - Mar. 1998 |
| Dickinson, ND | physical access | Jan. - Mar. 1998 |
| Wetzel County, WV | physical access | Jan. - Mar. 1998 |
| Twin Falls, ID | lack of sign language interpreter and communication assistance | Oct. - Dec. 1997 |
| Philadelphia, PA | lack of procedures for jurors to request accommodations | Oct. - Dec. 1997 |



| | | |
|---|---|---|
| Boone County, IN | lack of assistive listening devices | July - Sep. 1997 |
| Grand Rapids, MI | lack of assistive listening devices | July - Sep. 1997 |
| Outagamie County, WI | physical access and lack of assistive listening devices | Apr. - June 1997 |
| Rome, NY | physical access | Jan. - Mar. 1997 |
| Hancock County, MS | assistive listening (deaf individual excluded from jury service) | Jan. - Mar. 1997 |
| Harrison County, MS | assistive listening (deaf individual excluded from jury service) | Jan. - Mar. 1997 |
| Roswell, NM | lack of assistive listening devices | Jan. - Mar. 1997 |
| Santa Clara County, CA | lack of assistive listening devices | Oct. - Dec. 1996 |
| Jones County, CA | physical access | Oct. - Dec. 1996 |
| Town of Lloyd, NY | lack of communication assistance | July - Sep. 1996 |
| Tallahassee, FL | lack of communication assistance | Apr. - June 1996 |
| Pickens County, SC | lack of assistive listening devices | Oct. - Dec. 1994 |
| Fulton, MO | lack of communication assistance | Apr. - June 1994 |
| Wadsworth, OH | physical access | Apr. - June 1994 |

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|---|---|---|
| Alexandria, LA | lack of communication assistance and sign language interpreter | Apr. - June 1994 |
| Genesee County, MI | physical access | Apr. - June 1994 |
| Hickman County, KY | physical access | April 1994 |
| Van Buren County, AR | physical access | April 1994 |
| Harris County, TX | physical access and lack of communication assistance | April 1994 |
| Scott County, AR | physical access | April 1994 |
| Madison County, FL | physical access | April 1994 |
| Pinellas County, FL | lack of communication assistance | April 1994 |
| Salt Lake City, UT | lack of communication assistance (deaf individual excluded from jury) | April 1994 |
| Paulding County, OH | physical access | April 1994 |

**Complaints Resulting In Informal Settlement Agreements:**

| *Jurisdiction* | *Type of Problem* | *Status Report* |
|---|---|---|
| county in Ohio | lack of sign language interpreter | Jan. - Mar. 2003 |
| unnamed jurisdiction | lack of assistive listening devices | Jan. - Mar. 2003 |
| county in Mississippi | lack of sign language interpreter | Jan. - Mar. 2003 |
| county in Illinois | lack of sign language interpreter | Oct. - Dec. 2002 |
| county in Louisiana | lack of sign language interpreter | July - Sep. 2002 |



| | | |
|---|---|---|
| county in Pennsylvania | lack of accessible parking | Apr. - June 2002 |
| county in Arizona | physical access | Apr. - June 2002 |
| county in Nebraska | physical access | Jan. - Mar. 2002 |
| New England state court system | lack of sign language interpreter and assistive listening devices | Jan. - Mar. 2002 |
| county in Arizona | lack of assistive listening devices | Oct. - Dec. 2001 |
| county in Texas | lack of sign language interpreter | July - Sep. 2001 |
| county in California | physical access | July - Sep. 2001 |
| Iowa court | lack of sign language interpreter | July - Sep. 2001 |
| county in Texas | physical access | Oct. - Dec. 1999 |
| county in Oklahoma | physical access | Oct. - Dec. 1999 |
| county in Pennsylvania | physical access | Oct. - Dec. 1999 |
| county in Texas | lack of assistive listening devices | July - Sep. 1999 |
| county in Colorado | lack of accessible parking | July - Sep. 1999 |
| Michigan court | lack of communication assistance | July - Sep. 1999 |
| city in Pennsylvania | physical access | July - Sep. 1999 |
| town in Ohio | physical access | Oct. - Dec. 1998 |
| county in Michigan | physical access | Oct. - Dec. 1998 |
| Louisiana parish | physical access | Apr. - June 1998 |
| county in Michigan | physical access | Apr. - June 1998 |
| county in Illinois | lack of communication assistance | Jan. - Mar. 1998 |
| county in Michigan | lack of assistive listening devices | Oct. - Dec. 1997 |

| | | |
|---|---|---|
| county in Arizona | lack of communication aids | Oct. - Dec. 1997 |
| county in Florida | physical access | July - Sep. 1997 |
| Tennessee circuit court | lack of communication aids | July - Sep. 1997 |
| county in California | lack of assistive listening devices | Apr. - June 1997 |
| county in Michigan | lack of auxiliary aids | Jan. - Mar. 1997 |
| supreme court of a "southern state" | lack of auxiliary aids | Jan. - Mar. 1997 |
| Colorado judicial district | lack of auxiliary aids | Jan. - Mar. 1997 |
| county in Wyoming | physical access | Jan. - Mar. 1997 |
| county in Michigan | physical access | Oct. - Dec. 1996 |
| county in Virginia | lack of auxiliary aids | Oct. - Dec. 1996 |
| city in California | lack of auxiliary aids | July - Sep. 1996 |
| county in West Virginia | physical access | July - Sep. 1996 |
| county in Washington | lack of visual communication assistance | Apr. - June 1996 |
| county in California | lack of accessible parking | Apr. - June 1996 |
| county in Pennsylvania | physical access | Jan. - Mar. 1995 |
| "western state court" | lack of assistive listening devices | Oct. - Dec. 1994 |
| Ohio court | lack of communication assistance | Oct. - Dec. 1994 |
| county in Kentucky | physical access | July - Sep. 1994 |
| county in Colorado | physical access | July - Sep. 1994 |
| county in Colorado | physical access | Apr. - June 1994 |



| | | |
|---|---|---|
| county in Missouri | physical access | April 1994 |
| "various cities and towns in East and Midwest" | physical access | April 1994 |
| county in Washington | physical access | April 1994 |
| Michigan court | lack of assistive listening devices | April 1994 |
| Pennsylvania county court | lack of accommodation for person with learning disability | April 1994 |

**Complaints Resulting In Mediation:**

| *Jurisdiction* | *Type of Problem* | *Status Report* |
|---|---|---|
| county in Illinois | physical access | Oct. - Dec. 2002 |
| county in Arkansas | physical access | Oct. - Dec. 2001 |
| town in New York | physical access | Oct. - Dec. 2001 |
| county in South Carolina | lack of sign language interpreter | July - Sep. 2001 |
| county in California | physical access | Apr. - June 2001 |
| county in Tennessee | physical access | Jan. - Mar. 2000 |
| county in Nebraska | physical access | Jan. - Mar. 2000 |
| Michigan court | lack of sign language interpreter | July - Sep. 1997 |

In addition to the settlement agreements reported in the published status reports, there are several additional formal settlement agreements entered into between the Justice Department and various jurisdictions in cases dealing with courthouses. Although they are not reported in the status reports, they are available on the website: http://www.ada.gov

| *Jurisdiction* | *Problem* | *Date of Agreement* |
|---|---|---|
| Summers County, WV | physical access and lack of assistive listening devices | 5/11/00 |
| Craig County, VA | physical access | 1/30/02 |
| Allendale County, SC | physical access | 8/13/01 |
| Butte County, SD | physical access | 7/31/01 |
| Boulder County, CO | physical access | 10/2/00 |
| Warren County, IL | physical access | 9/6/01 |
| Perry County, KY | physical access | 9/25/01 |
| City of Cambridge, OH | physical access | 11/1/01 |
| City of San Antonio, TX | physical access | 1/30/02 |
| City of Savannah, GA | physical access | 1/30/02 |
| City of Bismarck, ND | physical access | 10/16/02 |
| Columbia County, NY | physical access | 5/19/03 |
| Loudon County, TN | physical access and lack of assistive listening devices | 7/25/03 |
| Madison County, MS | physical access | 7/25/03 |
| Worcester County, MD | physical access | 7/28/03 |

**APPENDIX C**

**Findings of Investigations Under the Civil Rights Of Institutionalized Persons Act 42 U.S.C. 1997 et seq.**

Between 1980 and the enactment of Title II of the Americans with Disabilities Act in 1990, Department of Justice investigations under the Civil Rights of Institutionalized Persons Act, 42 U.S.C. 1997 *et seq.*, found unconstitutional treatment of individuals with disabilities in institutions in more than twenty-five States. From 1980 until the present, unconstitutional conditions have been found in more than 200 institutions in more than thirty States throughout the Country. The Tables below describe some of the findings issued by the Department of Justice pursuant to 42 U.S.C. 1997b(a)(1). Copies of the complete findings letters will be provided to the Court upon request, and have been served upon counsel for the petitioner and the private respondents.

## I. Investigations Prior to Enactment of the Americans with Disabilities Act

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| **Rosewood Center** | MD | 1982 | Failure to provide reasonable supervision and safety | Many residents sustained injuries during "low staffing periods" (p. 4).<br><br>One resident left the facility unobserved and died of exposure. A profoundly retarded resident drowned when staff left him unattended in a bathtub. Another died after being pushed down a flight of stairs (pp. 4-5).<br><br>On another occasion, "six severely handicapped female residents * * * were allegedly raped by an outside intruder. There was only one staff person on duty to supervise the 32 residents * * * and only one security officer on duty to cover the entire Rosewood facility. While the inability of the residents to communicate apparently prevented state officials from confirming the rapes * * * several of the residents had positive tests for gonorrhea of the throat right after the incident" (p. 4).<br><br>Several male patients "show[ed] the presence of venereal disease" and "nonconsensual sexual contact occurred between one resident and at least one and possibly three residents" (p. 4). |
| | | | Abuse of residents | An employee sexually abused a resident (p. 4). |
| | | | Unsanitary conditions | Facilities are deteriorating; the "stench of urine is prevalent in a number of buildings." Plumbing problems left overflowing toilets unrepaired for days; heating problems subjected patients to "sub-freezing temperature in the buildings themselves" at times (p. 5). |
| | | | Inadequate training | "Over 900 of the 1125 residents receive less than 50% of the services |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | called for in their program plans" (p. 2). |
| **East Louisiana State Hospital** | LA | 1982 | Inadequate medical and mental health care | pp. 2-4 |
| **Enid & Paul's Valley State Schools** | OK | 1983 | Inadequate medical and mental health care | "Insufficient licensed physician coverage has resulted in serious harms to residents," contributing to patient deaths (p. 2-3). |
| | | | Inadequate training | Lack of training "contributes to and manifests itself in residents' aggressive and stereotypic behaviors * * * [such as] incessant disordered physical movements, headbanging, biting, hyperactivity, and assaultive behavior" (p. 5). |
| | | | Failure to provide reasonable supervision and safety | "For example, a group of 21 naked residents were observed being led to a shower area, where two staff sprayed the residents down with a large garden type hose" (p. 5). |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | Unreasonable use of physical and chemical restraints | p. 5 |
| | | | Abuse of residents | Staff found "slapping, kicking, hitting, or spanking residents" while records also "reflect many instances of unexplained resident injuries" (p. 6). |
| | | | Unsanitary conditions | Lack of sanitation practices contributed to parasitic and bacterial infections requiring quarantine of entire living areas (p. 6). |
| **Wheat Ridge Regional Center** | CO | 1984 | Failure to provide reasonable supervision and safety | "Due to lack of staff, residents suffer neglect and numerous accidents and injuries. * * * [N]umerous residents have sustained injuries where the cause remains unknown. Resident on resident assaults are common; residents engaging in self-abusive behaviors are frequently unsupervised and unattended. Residents have been |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | found with unexplained broken bones and burns to the body. For example, one resident was found with a femur segment protruding through the skin" (p. 2).<br><br>During tour, staff came upon "approximately 20 adult women being cared for by one person amid great disorder and confusion. Many of these women were partially undressed, one was urinating on the floor of the living area and several were engaging in self-abusive behavior" (p. 2). |
| | | | Inadequate medical and mental health care | "A large number of Wheat Ridge residents suffer from severe contractures of their limbs and other body deformities due to the absence of necessary physical and occupational therapy" (p. 3). "One troublesome secondary effect of these immobilizing contractures due to lack of physical |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | therapy is the dysfunctioning of the digestive system," which has apparently caused an "abnormally high percentage of Wheat Ridge residents to require pureed diets or gastroatomies for tube feeding" (p. 4). |
| **Logansport State Hospital** | IN | 1984 | Inadequate medical and mental health care | pp. 1-2 |
| | | | Failure to provide reasonable supervision and safety | "Patients are not being adequately monitored and supervised to prevent suicidal behavior or patient-on-patient violence, to notice and correctly diagnose symptoms of serious, physical or psychiatric dysfunctions, to monitor treatment responses and drug reactions, or to determine appropriate and reasonably safe modes of treatment for each patient" (pp. 2-3). |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| **Manteno and Eglin Mental Health Centers** | IL | 1984 | Inadequate medical and mental health care; Inadequate training; Unreasonable use of physical restraints | Lack of professional staff lead to "inappropriate uses of drugs and serious treatment errors which have resulted in physical danger to, or unnecessary physical or chemical restraint of, the involved patients" (p. 3). Patients are further "endangered by inadequate medical care relating to serious and sometimes debilitating or life-threatening drug side-effects" (p. 4). |
| | | | Failure to provide reasonable supervision and safety | "Units in the facilities are overcrowded to a point that makes it virtually impossible for staff to maintain control without regular and extensive use of physical and chemical restraints" (p. 4). |
| | | | Unsanitary conditions | "Sanitation and maintenance in portions of the facilities are so inadequate as to present serious risks to patients of poisoning, |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | infection, or disease" (pp. 4-5). |
| **Northville Regional Psychiatric Hospital** | MI | 1984 | Failure to provide reasonable supervision and safety; Abuse of residents | Large number of patient deaths under unusual circumstances, some associated with restraint practices (p. 3).<br><br>A patient died after "a stranglehold was applied to him while he was being subdued. He reportedly lay on the seclusion room floor from 15-20 minutes before efforts were made to resuscitate him" (pp. 2-3).<br><br>"Another patient also died due to strangulation, and his body showed signs of a beating" (p. 3).<br><br>"A third patient allegedly died from injuries suffered in a beating. Still another patient, who had expressed her fear for her safety to her psychologist on a Friday, died over the weekend. Her body allegedly was bruised and battered" (p. 3). |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | Police found that another patient who had died in a seclusion cell "had contusions on his face and the back of his head" (p. 3).<br><br>There have also been "numerous incidents of rape, assault and threat of assault, broken bones and bruises" (p. 3).<br><br>A staff member was found to have had "sexual relations with three different patients in one night." Other patients were beaten by staff, "including one who was stripped, placed in seclusion and severely beaten by several attendants" (p. 3). |
| | | | Inadequate medical and mental health care | Inadequate medical care contributed to several deaths and preventable suicides (pp. 3-4). |
| **Fairview Training Center** | OR | 1985 | Inadequate training | Training "is virtually non-existent" and "results in a serious level of self-injurious and aggressive behaviors" (p. 3). |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | Unreasonable use of physical and chemical restraints | "[R]estraints are used at Fairview in lieu of training and for the convenience of staff," and were employed more than 2,000 times per month (p. 4). |
| | | | Failure to provide reasonable supervision and safety | Records showed "an alarmingly high number of injuries," such as 197 incidents of injuries in one month resulting from self-abuse or aggression. In one two-month period, there were 27 incidents of sexual abuse (p. 3 n.1).<br><br>"[W]e observed numerous residents with open wounds, gashes, abrasions, contusions, and fresh bite marks. Many other residents had deep scars and scabs from a long history of self-abuse or victimization" (p. 3).<br><br>Due to inadequate supervision of residents with pica behavior (ingesting inedible objects), "[r]esidents have had to undergo |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | surgery, sometimes on a repeated basis, to remove foreign objects or to relieve bowel and other obstructions caused by pica. Physicians at Fairview have indicated that some residents have had surgery so frequently that any more operations resulting from pica would jeopardize their lives" (p. 8). |
| | | | Inadequate medical and mental health care | Dangerous psychotropic medication practices (p. 7-8).<br><br>"Seventy percent of residents institution-wide have gum disease" (p. 8). |
| | | | Unsanitary conditions | "Many of the cottages we toured smelled of urine and waste. Sewage backup in cottage basements, up to three feet high on the walls, is permitted to remain for days. * * * [A]n August 1983 random sample of Fairview residents revealed |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | that 35% had pinworm infection, a parasite which is spread by fecal and oral routes in unclean environments" (p. 9). |
| **Fort Stanton Hospital & Training School** | NM | 1985 | Inadequate medical and mental health care | Facilities' sole physician wrote institution-wide prescriptions for prescription medications and powerful psychotropic medications, authorizing their use when nursing staff believes it necessary, in contravention of professional standards and creating substantial risk to patients (p. 2). |
| | | | Unreasonable use of chemical restraints | Psychotropic drugs being used to restrain patients without any physician assessment for the need for such measures (p. 2.) |
| | | | Inadequate mental health care | "Many residents are subjected to potentially dangerous" prescriptions of multiple psychotropic drugs |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | "without any medical justification" (p. 2) |
| **Southbury Training School** | CT | 1985 | Failure to provide reasonable supervision and safety | Low staffing levels lead to inadequate supervision, which permitted one resident to leave the facility and die of exposure; another was able to remove and hide a large knife (p. 10).<br><br>In one cottage, staff compensate for low staffing level by placing "at least one resident in restraints for up to 12 hours a day due to the staff's inability to monitor his activities" (p. 10). |
| | | | Inadequate medical and mental health care | Investigation found "dangerous medication interactions and errors, and found that acute medical problems, such as fractures and infections, frequently do not receive critically necessary follow-up treatment" (p. 3). |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | Use of psychotropic medications substantially departed from professional standards, creating substantial health risks for patients (pp. 3-6). |
| | | | Inadequate training; Unreasonable use of physical and chemical restraints | Facility's failure to provide adequate training program resulted in "a dangerous reliance on the use of both physical and chemical restraint" (p. 6). |
| **Hinds County Detention Center** | MS | 1986 | Inadequate medical and mental health care | County Jail was being used to house mentally ill persons awaiting civil commitment hearings or placement in a mental hospital for up to eleven days. At time of investigation, jail held 42 mentally-ill detainees (pp. 1-2).<br><br>No mental health treatment was provided during period of confinement (p. 3).<br><br>"Male mentally-ill detainees were confined * * * in a small cell designed to serve as the |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | 'drunk tank.' Some of the detainees were placed in hand and leg irons" (p. 3). |
| **Westboro State Hospital** | MA | 1986 | Unsanitary conditions | "The smell and sight of urine and feces pervade not only the toilet areas, but ward floors and walls as well" (p. 3).<br><br>"Bathrooms and showers were filthy. Living areas are infested with vermin. There are consistent shortages of clean bed sheets, face cloths, towels and underwear. Open commodes with human waste in them were often found in rooms to which many patients in unclean geri-chairs are confined all day, including meal times" (p. 3).<br><br>"[N]on-sterile techniques are used when changing patients' dressings and feeding tubes" (p. 3). |
| | | | Inadequate medical and mental health care | Patients' physical illnesses are often misdiagnosed as psychological |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | problems, resulting in "increased dosages of potentially dangerous antipsychotic drugs" (p. 5).<br><br>"Acutely life threatening illnesses * * * are also not detected appropriately or on a timely basis.* * *<br><br>[I]nappropriate and inadequate medical care preceded many of the[] deaths" reviewed during the investigation (p. 5).<br><br>"Patients also frequently do not receive prescribed medications because the ward or pharmacy lacks adequate supplies" (p. 4). |
| | | | Unreasonable use of physical and chemical restraints | Facility used sedating drugs on elderly patients for no medically justifiable reason, but instead to control residents' behavior "subjecting vulnerable geriatric patients to the dangerous effects of |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | inappropriate drug usage and over-medication" (p. 7). |
| | | | Failure to provide reasonable supervision and safety; Inadequate training | pp. 7-8 |
| **Kalamazoo Regional Psychiatric Hospital** | MI | 1986 | Inadequate training; Unreasonable use of physical restraints | Inadequate staffing prevents the facility from providing treatment that could "reduce or eliminate unreasonable risks to [patients'] personal safety and the undue use of bodily restraint" (p. 2). |
| | | | Inadequate medical and mental health care | Facility fails to adequately monitor efficacy and side effects of potentially dangerous drugs, creating unjustifiable risk of "deleterious side effects, tardive dyskinesia, involuntary, abnormal muscle movements, akathisia, and parkinsonism" (p. 3). |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| **Napa State Hospital** | CA | 1986 | Failure to provide reasonable supervision and safety; Unreasonable use of physical and chemical restraints | Severe staffing shortages "result in patient management, in lieu of treatment, through the inappropriate use of seclusion, chemical restraint, and physical restraint" (p. 2).<br><br>Restraint practices "pose significant hazards to the personal safety of NSH patients" (p. 4). |
| | | | Inadequate medical and mental health care; Inadequate training | Certain medication practices at facility "violated all known standards of medical practice" resulting in great danger to patient safety (p. 2).<br><br>There was no monitoring of drug side effects and several patients exhibited an "antipsychotic drug-induced side effect, potentially irreversible, that may result in permanent physiological damage" (p. 3). |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | Facility failed to provide training programs adequate to protect patient safety and avoid need for restraint and seclusion (p. 5). |
| **Metropolitan Developmental Center** | LA | 1986 | Inadequate medical and mental health care | "MDC employs antipsychotic medication primarily as a means of controlling behavior without proper [medical] justification." As a result, "[n]umerous residents demonstrated serious neurological side effects from sustained exposure to high doses of antipsychotic drugs" (p. 2). Facility had no program to monitor for serious, potentially irreversible side effects of these medications (pp. 2-3).<br><br>Other residents "have been exposed to an extreme risk of drug-induced toxic poisoning by the absence of preliminary and periodic drug-level testing" (p. 3). |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| **Belle Chasse State School** | LA | 1986 | Inadequate medical and mental health care | Administration of psychotropic drugs substantially departed from professional standards. There was no program to detect "Tardive Dyskinesia" which is "an antipsychotic drug induced side effect, potentially irreversible, that may result in permanent physiological damage" (p. 2). |
| **Broadview, Cleveland & Warrensville Developmental Centers** | OH | 1987 | Inadequate training; Unreasonable use of chemical restraints | In the absence of adequate training programs, "staff overuse psychotropic medication to control the behavior of residents" (p. 1). |
| | | | Inadequate mental health care | p. 2 |
| **Montgomery Developmental Center** | OH | 1987 | Inadequate medical and mental health care; Failure to provide reasonable supervision and safety | pp. 2-3 |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| **Los Lunas Hospital and Training School** | NM | 1988 | Inadequate training; Unreasonable use of chemical restraints | "[S]traightjackets and ammonia inhalants are used as a consequence for antisocial behavior. Restrained individuals are in some cases isolated in a room with a closed door out of sight of staff. This practice, absent adequate surveillance, places severely handicapped residents at great risk of injury and is not professionally justifiable" (p. 2).<br><br>"Los Lunas staff are using physical restraints, isolation and punishment * * * to control the behavior of residents in lieu of necessary training programs" (p. 2). |
| | | | Failure to provide reasonable supervision and safety | Due to lack of supervision, a woman was raped, developed peritonitis, and died (p. 3). |
| | | | Inadequate medical and mental health care | Facility provides almost no physical therapy to the large number of patients with body deformities who need |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | therapy "to prevent muscular or skeletal breakdown" (p. 3). |
| **W.A. Howe Developmental Center** | IL | 1989 | Inadequate training; Unreasonable use of physical and chemical restraints | "To control resident behavior, in lieu of professionally designed training programs, staff resort to chemical and physical restraints" (p. 3). |
| | | | Inadequate medical and mental health care | "Due to the lack of adequate medical supervision of patients, early signs of illness and disease go undetected and/or untreated" (p. 5). |
| | | | Failure to provide reasonable supervision and safety | Patient was dead on the floor of her room for some time before staff discovered her, after staff failed to perform scheduled room checks.<br><br>A patient strangled to death while left unsupervised in improperly-applied restraints.<br><br>A resident who was left unsupervised ran out the front door and into traffic, where she was killed (pp. 6-7). |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| **Great Oaks Center** | MD | 1990 | Failure to provide reasonable supervision and safety; Inadequate training | Investigation found that inadequate supervision contributed to "an alarmingly high frequency of resident injuries" (p. 5).<br><br>Inadequate training program "fails to reduce self-abusive, aggressive, and other maladaptive and inappropriate behaviors." "As a result of these problems, rocking, pacing, and aimlessly wandering residents were seen throughout the institution. Instances of self-abuse were not an uncommon sight; observed attempts to intervene appropriately were rare. Many residents were observed to have cuts, bruises and scrapes. Clearly, many of the injuries may have been preventable with more effective programming and if more trained staff were available" (p. 3). |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | Unreasonable use of physical and chemical restraints | "Staff resort to chemical and physical restraints to control residents' behavior, in lieu of professionally designed training programs" (p. 3). |
| | | | Inadequate mental health care | p. 4 |
| | | | Abuse of residents | A number of staff had been disciplined or criminally charged for abusing patients (p. 5 n.1). |
| **Hawaii State Hospital** | HI | 1990 | Inadequate food, clothing and shelter | Staff at facility confirmed that there was often insufficient food; "Staff reported that patients are often wrapped in blankets and sheets due to the absence of adequate clothing"; inadequate items for basic personal hygiene (p. 2). |
| | | | Unsanitary conditions | "[S]anitation is grossly inadequate. During a tour of [one unit] our consultants had to walk around numerous puddles of urine. * * * * Kitchen facilities exhibited signs of serious cockroach |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | infestation and other unsanitary practices" (p. 3). |
| | | | Inadequate medical and mental health care | "[D]rug practices at HSH are seriously deficient and represent significant departures from generally accepted medical standards" (p. 3). |
| | | | Unreasonable use of physical and chemical restraints; Inadequate training | "In view of serious, chronic and facility-wide staffing shortages, HSH staff employ bodily restraints -- physical restraints, seclusion, and chemical restraints -- at an unjustifiably high level solely for their own convenience or in lieu of professionally designed treatment programs" (p. 5). |



## II. Investigations Subsequent To Enactment of the Americans with Disabilities Act

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| **Arlington Developmental Center** | VA | 1991 | Failure to provide reasonable supervision and safety; unsanitary conditions | "In many units, there was a pervasive smell of urine. Residents in diapers were wet; often their clothes were soaked through with urine" (p. 3). |
| | | | Inadequate medical care | "[W]e observed young children, some as young as two, whose limbs were severely contracted" from lack of physical therapy. "Many residents were left unattended in cribs, with no efforts being made to move their limbs, position them, or to provide any real physical therapy services" (p. 3).<br><br>"The penis of another resident, a paraplegic with an in-dwelling Foley catheter, was eroded throughout its entire length due to inadequate care and monitoring" (p. 3). |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | Inadequate medical care contributed to deaths of five residents in past six months (p. 4). |
| | | | Abuse of residents | pp. 3-4 |
| | | | Inadequate training | pp. 8-9 |
| **Northern Virginia Training Center** | VA | 1991 | Inadequate training; Unreasonable use of physical and chemical restraints | In part because of inadequate training programs, use of restraints was pervasive: "restraint is used so frequently that it appears to be the treatment of choice rather than a technique of last resort" (p. 4). |
| | | | Inadequate medical and mental health care | "Serious medical conditions and marked functional deterioration are not comprehensively evaluated or effectively treated" due to inadequate medical system (p. 5). |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| **Boswell Retardation Center** | MS | 1991 | Inadequate training; Unreasonable use of physical and chemical restraints | "Boswell's staff are using restraints, isolation and punishment to control the behavior of residents in lieu of necessary training programs" (p. 2). |
| | | | Inadequate mental health care | pp. 3-4 |
| | | | Unsanitary conditions | p. 5 |
| **Embreeville Center** | PA | 1991 | Inadequate medical and mental health care | Delays in emergency medical care contributed to patient death (p. 2). |
| | | | Abuse of residents | Undercover agent observed repeated instances of abuse over nine-week period (p. 3). |
| | | | Inadequate training programs | p. 2 |
| **Agnews Developmental Center** | CA | 1991 | Unsanitary conditions | "Clients and residents smelled of urine and feces" (p. 2). |
| | | | Unreasonable use of physical and chemical restraints | Bodily restraint and medication used in lieu of training programs or adequate staff supervision (pp. 4-5). |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | Inadequate medical care | Investigation found "resident after resident whose legs had lost all muscle tone and whose hip, knee and ankle joints had become permanently fixed or cemented in place in a deformed frog-leg or windswept position due to months and even years of inactivity" (p. 2).<br><br>"[I]nordinate delays in diagnosing and responding to serious resident illness" placed large population of medically fragile patients at substantial risk (pp. 5-6) |
| | | | Abuse of residents | Administrators "confirmed to us that staff abuse of residents is a serious problem" (p. 2). |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| **Memphis Mental Health Institute** | TN | 1992 | Inadequate medical and mental health care | Deficiencies in the facility's medical care system contributed to two recent deaths (pp. 5-6). Lack of psychiatrists leads to serious errors in diagnosis and medication prescription (pp. 7-8). |
| | | | Unreasonable use of physical and chemical restraints | "Patients at MMHI are subjected to both an undue amount of bodily restraint and dangerous restraint practices" (p. 9).<br><br>"[S]taff members are placing patients inappropriately in physical restraints simply because they are confused or disoriented." Patients are also restrained while sedated, "a substantial departure from accepted standards of psychiatric care" (pp. 9-10). |
| **Fircrest Residential Habilitation Center** | WA | 1992 | Failure to provide reasonable supervision and safety | "[R]esidents suffer needless serious injuries" due to lack of supervision, including an average of "410 incidents per month for some |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | 440 residents" (p. 1).<br><br>"Numerous residents were seen with fresh wounds and lacerations, including shaved spots on heads revealing stitches and healing injuries; red marks and significant bruises; multiple scabs and scars, and large bandages or casts" (pp. 1-2).<br><br>"Our consultants observed residents engaged in self-injurious behavior, having seizures, masturbating in open view -- all without staff intervention of any kind" (p. 2).<br><br>"[O]ne resident was found dead in the day room of a living unit; the resident had been dead for up to three hours before her body was discovered by staff" (p. 2).<br><br>Dangerous positioning and feeding practices put residents' lives at risk (p. 2). |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | Inadequate training | "Due to a lack of human interaction and care, residents have developed significant stereotypic, maladaptive or anti-social behaviors" including "headbanging, eating foreign objects and pulling hair, to waving arms, flicking fingers and other self-stimulatory activities" (p. 1).<br><br>"Much of the anti-social, maladaptive behavior, injuries and use of restraints is attributable, in significant part, to the lack of * * * training programs" (p. 5). |
| | | | Unreasonable use of physical and chemical restraints | Physical restraints, including "staff incapacitating residents by holding them down involuntarily on the floor or elsewhere for a period of 'enforced relaxation'" were pervasively "used as punishment, for the convenience of staff and in lieu of training programs" (p. 4-5). |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| **Forrest County Jail** | MS | 1993 | Inadequate mental health care | "There are no mental health services available at the jail and the holding cells into which disturbed or mentally-ill * * * prisoners are placed pose a direct threat to their health and safety" (p. 2).<br><br>"During the course of our tour of the jail, our consultants observed a severely mentally ill inmate, clad only in an undershirt, housed in the general population" where he had been waiting for several weeks for a transfer to a mental health facility. "He had allegedly eaten some glass and was prone to defecate on the floor of the cell" (pp. 2-3). |
| **Arizona State Hospital** | AZ | 1993 | Unreasonable use of physical and chemical restraints | Patients "are routinely put into five-point restraints (a practice where a patient is restrained on a bed and bound by the ankles, by the wrists with the arms to the side, and by |



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| | | | - | a strap across the abdomen) and placed into a locked seclusion room" for convenience of staff. Leaving a restrained patient unsupervised creates "great risk of harm from choking and asphyxiation" (p. 2). |
| **Jones County Jail** | MS | 1993 | Inadequate medical and mental health care | Mentally ill inmates, and mentally ill persons detained pending civil commitment proceedings, housed in five-by-six foot steel cage, sometimes for months (p. 4). |
| **Chicago-Read Mental Health Center** | IL | 1993 | Inadequate mental health care; Inadequate training | pp. 1-2 |
| | | | Unreasonable use of physical restraints | p. 2-3 |
| **Sonoma Developmental Center** | CA | 1994 | Failure to provide reasonable supervision and safety | "As a result of inadequate supervision, residents have been subjected to numerous, serious, unnecessary injuries" (p. 2). |

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| | | | | In one incident, a resident drowned in a bathtub while unattended (p. 2).<br><br>In another, one resident was attacked by another with a knife (p. 2). |
| | | | Inadequate training | Training programs are inadequate and lead to harm from unaddressed behaviors and to the unnecessary and unreasonable use of physical and chemical restraints (pp. 4-6). |
| | | | Inadequate medical care | Improper feeding practices for severely disabled residents "subject them to severe risk of choking, aspiration and aspiration pneumonia" (p. 3).<br><br>"The lack of physical therapists and physical therapy services has led to the development of undue contractures, muscle atrophy, inappropriate body growth, and physical degeneration" (p. 3). |



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| | | | | "The failure of staff to properly maintain [tracheostomy] tubes subjects residents to the risk of death from suffocation and presents other significant health risks, including infection" (p. 3). |
| **Southern & Central Wisconsin Developmental Centers** | WI | 1994 | Failure to provide reasonable supervision and safety | Inadequate supervision has led to serious resident injuries. For example, one elderly resident with a condition that creates a great risk of falling was taken to the hospital for an injury caused by a fall, whereupon hospital staff noted that she had fallen 62 times that day (p. 10). |
| | | | Inadequate medical and mental health care | While facility has over 300 residents with seizure disorders, management practices are dangerously deficient; some patients kept on medications with strong and dangerous side effects for years after they are no longer necessary; some are kept on potentially |

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| | | | | dangerous drugs even though they are not helping. For example, one patient who had been seizure free for six years, was kept on medication even though lab results showed that dosage was too low to be having any effect and even though patient appeared to be suffering from dementia as a side effect of the drug (p. 3-4).<br><br>Facility's use of psychotropic medications substantially departs from professional standards, exposing patients to unnecessary risks of dangerous side effects (pp.7-9). |
| | | | Inadequate training; Unreasonable use of physical restraints | pp. 10-13 |



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| **Eastern State Hospital and Hancock Geriatric Center** | VA | 1994 | Inadequate mental health care; Inadequate training; Unreasonable use of physical and chemical restraints | pp. 1-6 |
| **Clover Bottom Developmental Center** | TN | 1995 | Failure to provide reasonable supervision and safety | Many injuries linked to lack of supervision; "in one seven month period, a resident received injuries on twenty-six occasions," half of which required stitches (pp. 3-4). |
| | | | Inadequate training programs | pp. 5-8 |
| | | | Inadequate medical and mental health care | "Residents languish in carts and ill-fitting wheelchairs, which exacerbate or allow physical deformities to progress -- in some cases to a point that the deformity may preclude a person from sitting upright in a wheelchair" (p.12). |

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| **Nat T. Winston Developmental Center** | TN | 1995 | Inadequate training; Unreasonable use of physical and chemical restraints | "NTWDC, because of the ineffectiveness of its behavioral programs, relies on physical and chemical restraints to control residents' behavior" (p. 3).<br><br>Lack of training programs and supervision contribute to high incidence of injuries, including "multiple bites, lacerations, broken bones, bruises and abrasions. One individual was injured 25 times * * * in an eight-month period. * * * Several residents were found attempting to cut themselves with knives or razorblades" (p. 4). |
| | | | Inadequate medical and mental health care | pp. 4-5 |
| | | | Unsanitary conditions | "Sanitary conditions were very poor at the food facility"; "Mold and mildew were prevalent throughout the refrigerators and |



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| | | | | coolers" because of plumbing leaks (pp. 5-6). |
| **Greene Valley Developmental Center** | TN | 1995 | Inadequate medical and mental health care | "Due to an inadequate medical care delivery system * * * residents are subjected to needless fractures, recurrent aspiration, preventable weight loss, recurring seizures, avoidable injuries, and other direct threats to their health" (p. 2).<br><br>Psychiatrists prescribing dangerous combinations of drugs "absent any rational justification in violation of medical standards" (p. 3). |
| | | | Failure to provide reasonable supervision and safety | Due to lack of supervision, residents "are repeatedly 'found with blood' on them from injuries that occur outside of staff supervision. On other occasions, residents' severe injuries are discovered only during bathing or at bedtime" (p. 5). |

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| | | | | "[O]ne eleven year old boy apparently lost the sight in one eye from repeated headslapping which resulted in a detached retina. Other residents were noted with swollen, disfigured features resulting from years of self-injury. Still others had permanent scars from continual self-mutilation of their faces and arms" (p. 6). |
| | | | Inadequate training | Many residents' "destructive behaviors remain unaddressed" by training programs. "For example, one resident had large scratches on her face that had been self-inflicted; our consultant psychologist was informed that there was no program to modify or eliminate this unsafe behavior." The same was true for a patient who repeatedly reopened a face wound and one who had a history of pica for almost 20 years (p. 7). |



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| **Northern Virginia Mental Health Institute** | VA | 1995 | Inadequate medical and mental health care | "[P]sychiatric care is grossly inadequate" and "poses direct threats to the health and safety of patients" (p. 3).<br><br>"A county hospital is located only a few hundred yards [away], yet there have been a number of well-publicized deaths which are linked to substantial delays in providing adequate medical care" (p. 4).<br><br>"[O]ne patient died partly because of a toxic buildup of antidepressants in her body. Another patient died from meningitis after a psychiatrist requested that she be seen by an internist who failed to appear to assess her life-threatening condition" (p. 4). |
| | | | Unreasonable use of physical and chemical restraints | "Due to inadequate staffing, NVMHI is unable to provide one-on-one monitoring for many residents who are suicidal or are in restraints or |

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| | | | | seclusion and require such close supervision. Patients have been injured while being restrained and are then left unattended by medical personnel" (p. 5). |
| | | | Failure to provide reasonable supervision and safety | "[T]he lack of supervision and care is so grave that patients have been subjected to severe harm, including death" (p. 5). |
| **Landmark Learning Center** | FL | 1996 | Failure to provide reasonable supervision and safety | pp. 3-4 |
| | | | Inadequate training and mental health care | pp. 4-10 |
| **Harold Jordan Habilitation Center** | TN | 1996 | Inadequate training and mental health care | pp. 3-4 |



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| **Northern Virginia Mental Health Institute** | VA | 1996 | Failure to provide reasonable supervision and safety | Problems with supervision persist: in the past year, there were 70 incidents of patients escaping from the facility, and an average of 27 incidents of patient self-injury and another 17 incidents of patient-on-patient violence each month (p. 7).<br><br>Patients repeatedly injured themselves even when "supposedly under careful supervision." "One patient committed approximately 12 such acts of self-injury while on 'special observation' status."<br><br>"One patient somehow managed to obtain a knife while in the seclusion room" (p. 7). |
| | | | Inadequate training | "[S]taff have resorted to calling the police and having patients arrested rather than addressing the underlying psychological issues" (p. 8). |

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| **Central State Hospital** | VA | 1997 | Failure to provide reasonable supervision and safety | Lack of staffing and failure to supervise patients leads to repeated incidents of preventable injury and suicide attempts (pp. 3-5).<br><br>One patient supposedly under 24-hour surveillance was found with 42 bruises over his body from unwitnessed incidents (p. 4). |
| | | | Inadequate medical and mental health care | pp. 5-7, 9-11 |
| | | | Unreasonable use of physical and chemical restraints | Facility's use of restraints substantially departs from professional standards (pp. 7-9).<br><br>Patient died after being left in five-point restraint on bed as punishment; her psychiatrist had warned facility staff not to restrain her because of seizure risk. Nonetheless, the "patient had spent over 300 hours of the last two months of her life in restraints" (p. 8). |



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| **Los Angeles County Jail** | CA | 1997 | Inadequate mental health care | Jail system housing approximately 1,700 mentally ill inmates provides virtually no treatment to most inmates other than medication (p. 8).<br><br>Jail exacerbates many inmates' illness by placing them in solitary confinement for 23 hours or more per day (p. 12). |
| | | | Failure to provide reasonable supervision and safety | Jail places many mentally ill inmates in general population, but requires them to wear uniforms that designate them as mentally ill. As a result, many inmates suffered from beatings and sexual assaults (pp. 14, 17). |
| **Centro de Reeducacion para Adultos** | PR | 1997 | Unsanitary conditions/ inadequate shelter | "Many of the buildings are dilapidated, decaying, and lack adequate plumbing and lighting." At one facility, "the showers do not work, the faucets do not work, and the toilets do not flush properly. In order to bathe the clients, staff dump |

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| | | | | water from water tanks into large movable garbage cans from which the staff manually extract water using smaller buckets to pour it on the residents." Lack of water means that staff cannot wash hands after changing some patients' diapers (p. 3). |
| | | | Inadequate training and mental health care; Failure to provide reasonable supervision and safety | Investigators found patient "sitting on the floor * * * moaning to himself. We noticed a stream of blood trickling down his helmet. * * * * When the nurse removed his helmet, we discovered that [the patient's] head had been severely damaged due to years of self-abuse and head banging. [He] had butted and rammed his head into walls and post corners so often that he had pushed back completely his hair and skin on the front half of his head." Nonetheless, "the Commonwealth has failed to provide [the patient] with |



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| | | | | professional psychological or behavioral services."<br><br>Investigation found many other such individuals not receiving adequate care (p. 6). |
| | | | Unreasonable use of physical and chemical restraints | "Restraints are prevalent at many of the institutions * * * and are related lack of behavioral programming, training, and professional mental health intervention. * * * * [S]taff use a bed sheet to tie [a client's] waist and torso to a bench and to one of the iron bars at the facility to keep her from walking around the building and engaging in aggressive, maladaptive behaviors such as biting and hitting other clients. Staff tie [another client] up in four-point restraints to her bed for the entire time she is menstruating" (p. 7) |

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| **Center for Integral Services** | PR | 1997 | Failure to provide reasonable supervision and safety | "On our tour of CIS, we generally found a dangerous environment for the clients. We noticed many CIS residents with fresh injuries, including lacerations and bruises, as well as historical remnants of past injuries suffered at CIS, such as disfiguring scars. Many clients had suffered facial injuries or severe injuries on the back of their heads with resulting deep scars and hair loss" (p. 3).<br><br>Parents of clients showed pictures of "son with a very swollen, bulbous, purple and black eye. The father told us that his son has suffered a host of other injuries at CIS including a broken nose, a severe knee injury * * * and various head injuries, some requiring sutures." Another picture showed a client with a black eye, "a bloody left eye socket, bloody swollen lips, and a |



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| | | | | face marked with fresh lacerations. The mother reported that her son has also suffered a fractured arm, numerous lacerations, bites, broken teeth" and "is now limited in the use of his hands to one index finger and thumb on each hand" (p. 4). |
| | | | Inadequate food, shelter and sanitation | "[T]he facility runs out of food monthly" and "is in a state of disrepair." "Residents have to sleep on beds with old, worn mattresses that are dirty and often wet." Toilets do not flush. As a result, "virtually all of the toilets on the men's side had urine and/or feces in them, producing a health hazard and an unpleasant, malodorous environment" (pp. 5-6).<br><br>"Staff admitted to us that they routinely bathe the male clients by lining them up naked and hosing them down |

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| | | | | in groups * * * with a garden hose" (pp. 6-7). |
| | | | Abuse of residents | Facility administrator acknowledged problems with protecting clients from staff abuse and stated that "one CIS staff member had recently been convicted for sodomizing a client" (p. 3). |
| | | | Unreasonable use of physical and chemical restraints | "CIS frequently uses restraints as a substitute for meaningful activity during the day or for appropriate programs to address maladaptive behaviors * * * to control residents they routinely use mechanical restraints, such as leather cuff belts (which are tied to the heavy metal beds around the limbs of the clients), restraint vests and straight jackets, and restraint nets" (p. 8). |



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| | | | Inadequate medical and mental health care | Facility "routinely runs out of certain critical drugs" such as anti-convulsant medications for epileptic patients, who suffered repeated untreated seizures as a result (pp. 5, 10).<br><br>"Most of the residents are put on psychotropic medication simply to control their behaviors without appropriate psychiatric assessments, diagnoses, treatment and monitoring" (p. 9). |
| | | | Inadequate training programs | pp. 7-9 |
| **Hammond Developmental Center and Pinecrest Developmental Center** | LA | 1997 | Failure to provide reasonable supervision and safety | Client went for weeks with an undetected fractured shoulder, even though obviously in pain and bruised (p. 6). |
| | | | Abuse of residents | Four staff members recently indicted for abusing residents, many other incidents of abuse documented by facility (pp. 4-5, 15-16). |

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| | | | Unreasonable use of physical and chemical restraints | "A staff member left a client in full mechanical restraints unattended for hours in a room with a known aggressor" while staff watched television (p. 5).<br><br>Failure to provide adequate training programs leads to some patients being in restraints virtually non-stop (p. 12).<br><br>Failure to monitor clients in restraints led to injuries (p. 12-13). |
| | | | Inadequate training | As a result of insufficient training programs, "residents' aberrant behaviors continue unabated, often get worse, and lead frequently to other destructive behaviors" (p. 10).<br><br>Staff in one unit withheld food from clients if they misbehaved (p. 10). |
| | | | Inadequate medical and mental health care | pp. 13-15 |



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| **Holly Center** | MD | 1998 | Failure to provide reasonable supervision and safety; Inadequate medical care | Improper feeding techniques for severely disabled residents contributed to a constant rate of hospitalization and several deaths from choking and severe respiratory problems (pp. 3-5).<br><br>Systemic inadequacies in medical care contributed to the recent death of a severely handicapped and retarded resident (pp. 7-8). |
| | | | Inadequate training | pp. 8-13 |
| **Davies County Detention Center** | KY | 1998 | Inadequate mental health care | No mental health services provided. "During our tour, we observed several acutely mentally ill individuals at the main jail, obviously in need of psychiatric evaluation and treatment, being left for days at a time in 'observation' -- *i.e.*, in a cell by themselves. One inmate was observed singing for hours on end, and eating his own feces" (p. 11). |

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| | | | | As a result of inadequate mental health and suicide prevention system, a 15-year-old boy killed himself (p. 12). |
| **New Castle Developmental Center** | IN | 1998 | Failure to provide reasonable supervision and safety; Inadequate training | "Injuries are pervasive throughout the campus. With a census of 164 individuals, New Castle averaged over 1,000 resident injuries/incidents on a monthly basis"; over a four-month period, "88 percent of New Castle residents sustained injuries; 82 percent of the residents were injured more than one time during this period" (pp. 2-3).<br><br>In a single month, one resident was assaulted 20 times and another was assaulted 19 times (p. 3).<br><br>"Other injuries are unwitnessed by staff, including bone fractures, bloodied noses and body bruises" (p. 3). |



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| | | | | "[W]e witnessed instances in which residents engaged in aggressive and self-injurious behaviors (including head slapping, hand biting, eye gouging and table banging) without appropriate and timely staff intervention (p. 4). |
| | | | Inadequate medical and mental health care | While half of residents have epilepsy, facility's seizure management practices dangerously depart from accepted medical practices, increasing risk of liver and permanent brain damage (pp. 5-6). Insufficient levels of nursing staff lead to failures to identify and treat serious medical problems (pp. 6-7). |
| **Georgia Juvenile Facilities** | GA | 1998 | Inadequate mental health care | Inadequate mental health care provided throughout State's juvenile detention facilities and training schools (pp. 9-11, 19-22).<br><br>Many mentally ill youth "end up locked in security units where they spend |

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| | | | | large portions of their days isolated in small rooms with few activities. In these units, and elsewhere, they are often restrained, hit, shackled, put in restraint chairs for hours, and sprayed with [pepper spray] by staff who lack the training and resources to respond appropriately to the manifestations of mental illness" (p. 20). |
| **Western State Hospital** | VA | 1999 | Inadequate medical and mental health care | Facility fails to identify and address mental health needs, leading to inadequate treatment and risk of harm. In one case, patient identified as suicidal was given no treatment to address suicidal urges and subsequently hanged himself in his room (pp. 3-4).<br><br>Physicians are not permitted to prescribe some medically-indicated drugs for budget reasons (pp. 5-6). |



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| | | | | Inadequate medical care contributed to several recent deaths (p. 8). |
| | | | Unreasonable use of physical and chemical restraints | Facility uses excessive and dangerous restraint techniques (p. 7). |
| | | | Failure to provide reasonable supervision and safety; Inadequate training | Combination of inadequate staffing and training for patients results in high level of violence and injuries. Within one 90-day period, the facility of 370 patients "recorded 169 altercations, 81 instances of self-injurious behavior, and 128 falls" as well as 8 suicide attempts and 13 escapes. In the recent past, one patient committed suicide and was dead for an hour before being discovered (p. 9). |
| **Rainier School & Frances Haddon Morgan Center** | WA | 1999 | Unreasonable use of physical and chemical restraints | "In 1998, Rainier logged many thousands of hours of restraint use, without demonstrating that less restrictive interventions were tried or that |

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| | | | | underlying behavioral support plans and services were adequate." For example, the facility's response to patients attempting to eat inedible objects (pica) or digging at their eyes or rectums was to place patients in nearly constant restraints: one patient with pica behavior spent 2,000 hours in a restraint suit over a six-month period; another averaged 600 hours per month for pica and rectal digging; another averaged 22 hours per day in the suit for rectal digging (pp. 2-3). |
| | | | Failure to provide reasonable supervision and safety; Inadequate training; Inadequate medical and mental health care | "Without the necessary specialized treatment, * * * residents have suffered serious harm. Residents * * * have blinded themselves from chronic behaviors, such as eye poking and head banging, that the facilities have not addressed in accordance with |



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| | | | | accepted professional standards" (p. 7).<br><br>Numerous incidents of unaddressed, dangerous behaviors, such as pica, head-banging, and eye-poking (pp. 7-8).<br><br>In one facility, "approximately 20 percent of all Morgan residents were admitted to the emergency room or hospital, some on more than one occasion, for treatment of injuries" in a one-year period; during same year residents in another facility "suffered approximately 77 lacerations requiring sutures (32 involving the head), 37 bone fractures, 8 dislocated shoulders, and 2 incidents of finger amputation" (p. 10). |
| **Clark County Detention Center** | NV | 1999 | Inadequate mental health care | Jail failed adequately to identify mentally ill inmates and provide appropriate |

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| | | | | treatment, resulting in serious harm and suicides (pp. 5-6). |
| **Mercer County Geriatric Center** | NJ | 2002 | Failure to provide reasonable supervision and safety | Staff fail to supervise geriatric patients. In one case "a family member used to visit at odd hours, only to find her unattended relative lying in urine, with parts of her naked body exposed" and with "unexplained skin bruises" (p. 3).<br><br>More than a third of patients need assistance with eating and drinking, but poor nutrition and hydration practices result in substantial weight losses, hospitalization for dehydration, and even death. In one case, a resident with "an improperly positioned feeding tube" "slowly starved without adequate MCGC staff intervention." In another case, "staff fed a resident so quickly, she aspirated and died" (p. 6). |



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| | | | Inadequate medical and mental health care | Staff "fail to assess and treat residents properly for potentially serious medical and mental health problems," including failure to prevent and treat "residents with deep, bleeding bedsores, infections, and other potentially life-threatening conditions" (p. 4). |
| | | | Unreasonable use of physical and chemical restraints | "Staff routinely restrain residents while the staff engage in various tasks" (p. 5). |
| **Banks-Jackson-Commerce Medical Center and Nursing Home** | GA | 2002 | Failure to provide reasonable supervision and safety, and unreasonable use of physical and chemical restraints | Staff failed to take adequate measures to prevent serious falls, other than to restrain patients to chairs and beds (p.3). Other patients are injured by staff when transferred to and from bed, due to inadequate staff available or improper staff training (p. 4). Recently, one unsupervised resident wandered out of the facility in a wheelchair "crashed into a sidewalk curb, |

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| | | | | overturned" and was seriously injured (p. 4). |
| | | | Inadequate medical and mental health care | Facility fails to provide physical therapy that could "prevent contractures (i.e., permanent muscular contraction)" due to lack of adequate staff to implement physical therapy orders (p. 6).<br><br>Failure to move and reposition patients led to development of pressure sores, some of which became infected and require hospitalization (pp. 6-7).<br><br>"[T]here is insufficient psychiatric consultation and oversight of medication use" at the facility; a psychiatrist visits the facility only 4 times per year. As a result, many patients have been on inappropriate doses or types of powerful psychiatric medications for years (pp. 9-10). |



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| | | | | "Approximately 60 residents at BJC have a diagnosis of depression, yet the facility fails to provide group or individual counseling, or other activities designed to treat depression" (p. 10). |
| | | | Inadequate food, clothing and shelter | While facility provided ample food and drink, it frequently failed to assist patients who needed feeding and drinking assistance. As a result, "numerous residents were hospitalized for conditions related to lack of adequate hydration" (p. 9). |
| **Oakwood Developmental Center** | KY | 2002 | Abuse of residents | Numerous incidents of staff abuse, leading to arrests of staff, including one incident in which "an Oakwood staff member stomped on a resident's head and rendered the resident unconscious" (p. 3). |

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| | | | Failure to provide reasonable supervision and safety | Very high incidence of harm to residents at facility. During one 3 month period, one patient "had 30 reported incidents of harm" (p. 4).<br><br>Even though treating professionals ordered close supervision of resident with pica, lax supervision permitted resident to engage in "at least 70 more attempted and/or actual incidents of pica behavior involving paper, trash, toilet paper, shoestrings, a washcloth, an ink pen, a sock, and fecal material." In another case, failure to supervise resulted in surgery to remove five plastic gloves staff had not observed the resident eating (p. 5). |
| | | | Unreasonable use of physical and chemical restraints | Lack of adequate behavior management leads to "increased use of physical and chemical restraints even though all of the Oakwood psychologists interviewed stated |



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| | | | | that restraints and other aversive or restrictive procedures such as helmets and mittens are unnecessary and unwarranted" (p. 7). |
| | | | Inadequate medical and mental health care | More than half of the psychiatric diagnoses for patients are incorrect (p. 9).<br><br>Many residents receive powerful psychotropic medications with potentially serious side effects "in place of adequate behavioral treatment plans" (p. 9).<br><br>Facility does not adequately monitor those on psychotropic medications for serious, potentially irreversible side effects (p. 10).<br><br>Although facility has more than 200 residents with seizure disorders, it provided neurology consultations for only 10-15 residents per month. As a result, many residents are simply |

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| | | | | put on powerful anti-convulsant medications that might not be necessary, if treated properly, and which have serious side effects. One patient had been on such medications daily for 25 years, even though he had not had a seizure since 1976 and there was no indication that he had been seen by a neurologist until 2001 (p. 14).<br><br>Failure to provide adequate medical monitoring and care had contributed to preventable resident deaths (p. 11).<br><br>On numerous occasions, nurses gave medication to wrong patient, and pills are found lying on floors of living areas (p. 16). |
| **Alexander Youth Services Center** | AK | 2002 | Inadequate medical and mental health care | Inadequate mental health care systems contributed to preventable suicides (pp. 4-6). |



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| | | | | Facility provided no professional individualized treatment, other than medication, to seriously mentally ill residents (p. 7). |
| **Nevada Youth Training Center** | NV | 2002 | Inadequate medical and mental health care | When mentally ill youth are receiving psychotropic medications at the time of entry into the facility, those "medications are automatically and permanently discontinued upon the youths' arrival" without individualized review by a medical professional (p. 9). |
| **Santa Fe County Adult Detention Center** | NM | 2003 | Inadequate medical and mental health care | Facility provides no qualified medical staff to treat inmates with serious mental illness, permitting counselors to make medical decisions about psychotropic medications (pp. 16-17). |
| **Nim Henson Geriatric Center** | NM | 2003 | Inadequate medical and mental health care | Facility medication practices substantially depart from professional |

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| | | | | standards, placing patients at risk (pp. 3-6)<br><br>Numerous patients put on feeding tubes unnecessarily, apparently for the convenience of staff (p. 11).<br><br>Mentally ill patients "either are untreated or treated incorrectly" (p. 15). |
| | | | Unreasonable use of physical and chemical restraints | Facility sedates elderly patients for convenience of staff (pp. 8-9). |
| **New Lisbon Developmental Center** | NJ | 2003 | Failure to protect from physical harm | Residents subjected to frequent physical harm by other residents as well as by facility's staff (pp. 3-6). |
| | | | Inadequate medical and mental health care | Inadequate medical care provided to residents with bowel obstructions and seizure disorders, placing residents at risk of serious complications (pp. 17-18).<br><br>Program to deal with behavioral problems does not comport with generally |



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| | | | | accepted practice and staff are inadequately trained (pp. 7-9). |
| | | | Unreasonable use of physical and chemical restraints | Unnecessary use of mechanical restraints (pp. 9-10).<br><br>Use of psychotropic drugs to control residents' behavior does not comport with generally accepted practices (pp. 10-11). |
| **Los Angeles County Juvenile Halls** | CA | 2003 | Inadequate medical and mental health care | Failure to treat an estimated 75% of juveniles in need of mental health care (p. 7).<br><br>Failure to comport with professional standards regarding psychological counseling (pp. 12-14).<br><br>Failure to administer psychotropic medications safely and effectively (pp. 14-16).<br><br>Failure to effectively treat youths on suicide watch (pp. 17-18). |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | Excessive use of force | Unjustified use of Oleoresin Capsicum spray, including against juveniles with respiratory problems (pp. 20-22). |
| | | | Failure to protect from physical harm | Juveniles frequently subjected to violence from other juveniles, resulting in "significant injury" (pp. 22-23). |
| **Garfield County Jail & Garfield County Work Center** | OK | 2003 | Inadequate medical and mental health care | Provision of medical services to inmates "is seriously deficient and places inmates at risk of harm" (p. 10).<br><br>Provision of mental health care inadequate, particularly in regard to suicide prevention (pp. 14-15). |
| **Metropolitan State Hospital** | CA | 2003 | Inadequate mental health care | Psychiatric services "substantially depart from generally accepted professional standards of care and expose the children and adolescents [in the facility] to a significant risk of harm and to actual harm" (p. 3). |



| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | Inappropriate use of psychotropic medications (pp. 9-11). |
| | | | Unreasonable use of physical and chemical restraints | Use of physical and chemical restraints "substantially departs" from standards of care and exposes children to "excessive and unnecessary restrictive interventions" (p. 25). |
| **Reginald P. White Nursing Facility** | MS | 2003 | Inadequate mental health care | "[I]nappropriate use of multiple medications" and "excessive reliance on psychotropic medications (chemical restraints)" (p. 8). |
| **Claudette Box Nursing Home** | AL | 2003 | Inadequate medical and mental health care | Facility administers "excessive or unnecessary doses of psychotropics" (p. 3). |
| **Oakley & Columbia Training Schools** | MS | 2003 | Unreasonable use of physical restraints | Use of physical restraints such as "[h]og-tying and [p]ole-shackling" despite lack of "penological justification or therapeutic or rehabilitative benefit" of such disciplinary methods (pp. 5-9). |

| Name of Facility | State | Year | Categories of Constitutional Violations | Details |
|---|---|---|---|---|
| | | | | |
| | | | Excessive use of force | Facility staff "use excessive force with impunity" (pp. 9-11). |
| | | | Inadequate mental health care | "Many youth on psychiatric medications are not allowed to continue to receive those medications when they are admitted" (p. 15).<br><br>Facilities "fail to employ adequate suicide prevention measures" (p. 16). |

## APPENDIX D

## CONSTITUTION OF THE UNITED STATES

### AMENDMENT XI

The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.

### AMENDMENT XIV

**SECTION 1.** All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

* * * * *

**SECTION 5.** The Congress shall have power to enforce, by appropriate legislation, the provisions of this article.

## SELECTED PROVISIONS OF THE AMERICANS WITH DISABILITIES ACT OF 1990, 42 U.S.C. 12101 *et seq.*

### § 12101. Findings and purpose

#### (a) Findings

The Congress finds that—

**(1)** some 43,000,000 Americans have one or more physical or mental disabilities, and this number is increasing as the population as a whole is growing older;

**(2)** historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;

**(3)** discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services;

**(4)** unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;

**(5)** individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards



and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;

**(6)** census data, national polls, and other studies have documented that people with disabilities, as a group, occupy an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally;

**(7)** individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society;

**(8)** the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals; and

**(9)** the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity.

#### (b) Purpose

It is the purpose of this chapter—

**(1)** to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;

**(2)** to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;

**(3)** to ensure that the Federal Government plays a central role in enforcing the standards established in this chapter on behalf of individuals with disabilities; and

**(4)** to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.



**Title II, Part A, of The Americans With Disabilities Act**

**§ 12131. Definitions**

As used in this subchapter:

**(1) Public entity**

The term "public entity" means—

(A) any State or local government;

(B) any department, agency, special purpose district, or other instrumentality of a State or States or local government; and

(C) the National Railroad Passenger Corporation, and any commuter authority (as defined in section 2410(4) of title 49).

**(2) Qualified individual with a disability**

The term "qualified individual with a disability" means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

**§ 12132. Discrimination**

Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

## § 12133. Enforcement

The remedies, procedures, and rights set forth in section 794a of title 29 shall be the remedies, procedures, and rights this subchapter provides to any person alleging discrimination on the basis of disability in violation of section 12132 of this title.

## § 12134. Regulations

### (a) In general

Not later than 1 year after July 26, 1990, the Attorney General shall promulgate regulations in an accessible format that implement this part. Such regulations shall not include any matter within the scope of the authority of the Secretary of Transportation under section 12143, 12149, or 12164 of this title.

### (b) Relationship to other regulations

Except for "program accessibility, existing facilities", and "communications", regulations under subsection (a) of this section shall be consistent with this chapter and with the coordination regulations under part 41 of title 28, Code of Federal Regulations (as promulgated by the Department of Health, Education, and Welfare on January 13, 1978), applicable to recipients of Federal financial assistance under section 794 of title 29. With respect to "program accessibility, existing facilities", and "communications", such regulations shall be consistent with regulations and analysis as in part 39 of title 28 of the Code of Federal Regulations, applicable to federally conducted activities under such section 794 of title 29.



### (c) Standards

Regulations under subsection (a) of this section shall include standards applicable to facilities and vehicles covered by this part, other than facilities, stations, rail passenger cars, and vehicles covered by part B of this subchapter. Such standards shall be consistent with the minimum guidelines and requirements issued by the Architectural and Transportation Barriers Compliance Board in accordance with section 12204(a) of this title.

* * * * *

## Title II, Part B, of The Americans With Disabilities Act

### § 12141. Definitions

As used in this subpart:

**(1) Demand responsive system**

The term "demand responsive system" means any system of providing designated public transportation which is not a fixed route system.

**(2) Designated public transportation**

The term "designated public transportation" means transportation (other than public school transportation) by bus, rail, or any other conveyance (other than transportation by aircraft or intercity or commuter rail transportation (as defined in section 12161 of this title)) that provides the general public with general or special service (including charter service) on a regular and continuing basis.

**(3) Fixed route system**

The term "fixed route system" means a system of providing designated public transportation on which a vehicle is operated along a prescribed route according to a fixed schedule.

**(4) Operates**

The term "operates", as used with respect to a fixed route system or demand responsive system, includes operation of such system by a person under a contractual or other arrangement or relationship with a public entity.

**(5) Public school transportation**

The term "public school transportation" means transportation by schoolbus vehicles of schoolchildren, personnel, and equipment to and from a public elementary or secondary school and school-related activities.



**(6) Secretary**

The term "Secretary" means the Secretary of Transportation.

### § 12142. Public entities operating fixed route systems

**(a) Purchase and lease of new vehicles**

It shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a public entity which operates a fixed route system to purchase or lease a new bus, a new rapid rail vehicle, a new light rail vehicle, or any other new vehicle to be used on such system, if the solicitation for such purchase or lease is made after the 30th day following July 26, 1990, and if such bus, rail vehicle, or other vehicle is not readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs.

**(b) Purchase and lease of used vehicles**

Subject to subsection (c)(1) of this section, it shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a public entity which operates a fixed route system to purchase or lease, after the 30th day following July 26, 1990, a used vehicle for use on such system unless such entity makes demonstrated good faith efforts to purchase or lease a used vehicle for use on such system that is readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs.

**(c) Remanufactured vehicles**

**(1) General rule**

Except as provided in paragraph (2), it shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a public entity which operates a fixed route system—

(A) to remanufacture a vehicle for use on such system so as to extend its usable life for 5 years or more, which remanufacture begins (or for which the solicitation is made) after the 30th day following July 26, 1990; or

(B) to purchase or lease for use on such system a remanufactured vehicle which has been remanufactured so as to extend its usable life for 5 years or more, which purchase or lease occurs after such 30th day and during the period in which the usable life is extended;

unless, after remanufacture, the vehicle is, to the maximum extent feasible, readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs.

**(2) Exception for historic vehicles**

**(A) General rule**

If a public entity operates a fixed route system any segment of which is included on the National Register of Historic Places and if making a vehicle of historic character to be used solely on such segment readily accessible to and usable by individuals with disabilities would significantly alter the historic character of such vehicle, the public entity only has to make (or to purchase or lease a remanufactured vehicle with) those modifications which are necessary to



meet the requirements of paragraph (1) and which do not significantly alter the historic character of such vehicle.

**(B) Vehicles of historic character defined by regulations**

For purposes of this paragraph and section 12148(b) of this title, a vehicle of historic character shall be defined by the regulations issued by the Secretary to carry out this subsection.

## § 12143. Paratransit as a complement to fixed route service

**(a) General rule**

It shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a public entity which operates a fixed route system (other than a system which provides solely commuter bus service) to fail to provide with respect to the operations of its fixed route system, in accordance with this section, paratransit and other special transportation services to individuals with disabilities, including individuals who use wheelchairs, that are sufficient to provide to such individuals a level of service (1) which is comparable to the level of designated public transportation services provided to individuals without disabilities using such system; or (2) in the case of response time, which is comparable, to the extent practicable, to the level of designated public transportation services provided to individuals without disabilities using such system.

**(b) Issuance of regulations**

Not later than 1 year after July 26, 1990, the Secretary shall issue final regulations to carry out this section.

**(c) Required contents of regulations**

**(1) Eligible recipients of service**

The regulations issued under this section shall require each public entity which operates a fixed route system to provide the paratransit and other special transportation services required under this section—

(A)(i) to any individual with a disability who is unable, as a result of a physical or mental impairment (including a vision impairment) and without the assistance of another individual (except an operator of a wheelchair lift or other boarding assistance device), to board, ride, or disembark from any vehicle on the system which is readily accessible to and usable by individuals with disabilities;

(ii) to any individual with a disability who needs the assistance of a wheelchair lift or other boarding assistance device (and is able with such assistance) to board, ride, and disembark from any vehicle which is readily accessible to and usable by individuals with disabilities if the individual wants to travel on a route on the system during the hours of operation of the system at a time (or within a reasonable period of such time) when such a vehicle is not being used to provide designated public transportation on the route; and

(iii) to any individual with a disability who has a specific impairment-related condition which prevents such individual from traveling to a boarding location or from a disembarking location on such system;

(B) to one other individual accompanying the individual with the disability; and

(C) to other individuals, in addition to the one individual described in subparagraph (B), accompanying



the individual with a disability provided that space for these additional individuals is available on the paratransit vehicle carrying the individual with a disability and that the transportation of such additional individuals will not result in a denial of service to individuals with disabilities.

For purposes of clauses (i) and (ii) of subparagraph (A), boarding or disembarking from a vehicle does not include travel to the boarding location or from the disembarking location.

**(2) Service area**

The regulations issued under this section shall require the provision of paratransit and special transportation services required under this section in the service area of each public entity which operates a fixed route system, other than any portion of the service area in which the public entity solely provides commuter bus service.

**(3) Service criteria**

Subject to paragraphs (1) and (2), the regulations issued under this section shall establish minimum service criteria for determining the level of services to be required under this section.

**(4) Undue financial burden limitation**

The regulations issued under this section shall provide that, if the public entity is able to demonstrate to the satisfaction of the Secretary that the provision of paratransit and other special transportation services otherwise required under this section would impose an undue financial burden on the public entity, the public entity, notwithstanding any other provision of this section (other than paragraph (5)), shall only be required to pro-

vide such services to the extent that providing such services would not impose such a burden.

**(5) Additional services**

The regulations issued under this section shall establish circumstances under which the Secretary may require a public entity to provide, notwithstanding paragraph (4), paratransit and other special transportation services under this section beyond the level of paratransit and other special transportation services which would otherwise be required under paragraph (4).

**(6) Public participation**

The regulations issued under this section shall require that each public entity which operates a fixed route system hold a public hearing, provide an opportunity for public comment, and consult with individuals with disabilities in preparing its plan under paragraph (7).

**(7) Plans**

The regulations issued under this section shall require that each public entity which operates a fixed route system—

(A) within 18 months after July 26, 1990, submit to the Secretary, and commence implementation of, a plan for providing paratransit and other special transportation services which meets the requirements of this section; and

(B) on an annual basis thereafter, submit to the Secretary, and commence implementation of, a plan for providing such services.

**(8) Provision of services by others**

The regulations issued under this section shall—



(A) require that a public entity submitting a plan to the Secretary under this section identify in the plan any person or other public entity which is providing a paratransit or other special transportation service for individuals with disabilities in the service area to which the plan applies; and

(B) provide that the public entity submitting the plan does not have to provide under the plan such service for individuals with disabilities.

**(9) Other provisions**

The regulations issued under this section shall include such other provisions and requirements as the Secretary determines are necessary to carry out the objectives of this section.

**(d) Review of plan**

**(1) General rule**

The Secretary shall review a plan submitted under this section for the purpose of determining whether or not such plan meets the requirements of this section, including the regulations issued under this section.

**(2) Disapproval**

If the Secretary determines that a plan reviewed under this subsection fails to meet the requirements of this section, the Secretary shall disapprove the plan and notify the public entity which submitted the plan of such disapproval and the reasons therefor.

**(3) Modification of disapproved plan**

Not later than 90 days after the date of disapproval of a plan under this subsection, the public entity which submitted the plan shall modify the plan to meet the requirements of this section and shall submit to the Secre-

tary, and commence implementation of, such modified plan.

**(e) "Discrimination" defined**

As used in subsection (a) of this section, the term "discrimination" includes—

**(1)** a failure of a public entity to which the regulations issued under this section apply to submit, or commence implementation of, a plan in accordance with subsections (c)(6) and (c)(7) of this section;

**(2)** a failure of such entity to submit, or commence implementation of, a modified plan in accordance with subsection (d)(3) of this section;

**(3)** submission to the Secretary of a modified plan under subsection (d)(3) of this section which does not meet the requirements of this section; or

**(4)** a failure of such entity to provide paratransit or other special transportation services in accordance with the plan or modified plan the public entity submitted to the Secretary under this section.

**(f) Statutory construction**

Nothing in this section shall be construed as preventing a public entity—

**(1)** from providing paratransit or other special transportation services at a level which is greater than the level of such services which are required by this section,

**(2)** from providing paratransit or other special transportation services in addition to those paratransit and special transportation services required by this section, or

**(3)** from providing such services to individuals in addition to those individuals to whom such services are required to be provided by this section.



**§ 12144. Public entity operating a demand responsive system**

If a public entity operates a demand responsive system, it shall be considered discrimination, for purposes of section 12132 of this title and section 794 of Title 29, for such entity to purchase or lease a new vehicle for use on such system, for which a solicitation is made after the 30th day following July 26, 1990, that is not readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, unless such system, when viewed in its entirety, provides a level of service to such individuals equivalent to the level of service such system provides to individuals without disabilities.

**§ 12145. Temporary relief where lifts are unavailable**

**(a) Granting**

With respect to the purchase of new buses, a public entity may apply for, and the Secretary may temporarily relieve such public entity from the obligation under section 12142(a) or 12144 of this title to purchase new buses that are readily accessible to and usable by individuals with disabilities if such public entity demonstrates to the satisfaction of the Secretary—

**(1)** that the initial solicitation for new buses made by the public entity specified that all new buses were to be lift-equipped and were to be otherwise accessible to and usable by individuals with disabilities;

**(2)** the unavailability from any qualified manufacturer of hydraulic, electromechanical, or other lifts for such new buses;

**(3)** that the public entity seeking temporary relief has made good faith efforts to locate a qualified manufac-

turer to supply the lifts to the manufacturer of such buses in sufficient time to comply with such solicitation; and

**(4)** that any further delay in purchasing new buses necessary to obtain such lifts would significantly impair transportation services in the community served by the public entity.

**(b) Duration and notice to Congress**

Any relief granted under subsection (a) of this section shall be limited in duration by a specified date, and the appropriate committees of Congress shall be notified of any such relief granted.

**(c) Fraudulent application**

If, at any time, the Secretary has reasonable cause to believe that any relief granted under subsection (a) of this section was fraudulently applied for, the Secretary shall—

**(1)** cancel such relief if such relief is still in effect; and

**(2)** take such other action as the Secretary considers appropriate.

**§ 12146. New facilities**

For purposes of section 12132 of this title and section 794 of Title 29, it shall be considered discrimination for a public entity to construct a new facility to be used in the provision of designated public transportation services unless such facility is readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs.

**§ 12147. Alterations of existing facilities**

**(a) General rule**

With respect to alterations of an existing facility or part thereof used in the provision of designated public transportation services that affect or could affect the usability of the



facility or part thereof, it shall be considered discrimination, for purposes of section 12132 of this title and section 794 of Title 29, for a public entity to fail to make such alterations (or to ensure that the alterations are made) in such a manner that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, upon the completion of such alterations. Where the public entity is undertaking an alteration that affects or could affect usability of or access to an area of the facility containing a primary function, the entity shall also make the alterations in such a manner that, to the maximum extent feasible, the path of travel to the altered area and the bathrooms, telephones, and drinking fountains serving the altered area, are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, upon completion of such alterations, where such alterations to the path of travel or the bathrooms, telephones, and drinking fountains serving the altered area are not disproportionate to the overall alterations in terms of cost and scope (as determined under criteria established by the Attorney General).

**(b) Special rule for stations**

**(1) General rule**

For purposes of section 12132 of this title and section 794 of Title 29, it shall be considered discrimination for a public entity that provides designated public transportation to fail, in accordance with the provisions of this subsection, to make key stations (as determined under criteria established by the Secretary by regulation) in rapid rail and light rail systems readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs.

**(2) Rapid rail and light rail key stations**

**(A) Accessibility**

Except as otherwise provided in this paragraph, all key stations (as determined under criteria established by the Secretary by regulation) in rapid rail and light rail systems shall be made readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, as soon as practicable but in no event later than the last day of the 3-year period beginning on July 26, 1990.

**(B) Extension for extraordinarily expensive structural changes**

The Secretary may extend the 3-year period under subparagraph (A) up to a 30-year period for key stations in a rapid rail or light rail system which stations need extraordinarily expensive structural changes to, or replacement of, existing facilities; except that by the last day of the 20th year following July 26, 1990, at least 2/3 of such key stations must be readily accessible to and usable by individuals with disabilities.

**(3) Plans and milestones**

The Secretary shall require the appropriate public entity to develop and submit to the Secretary a plan for compliance with this subsection—

(A) that reflects consultation with individuals with disabilities affected by such plan and the results of a public hearing and public comments on such plan, and

(B) that establishes milestones for achievement of the requirements of this subsection.



**§ 12148. Public transportation programs and activities in existing facilities and one car per train rule**

**(a) Public transportation programs and activities in existing facilities**

**(1) In general**

With respect to existing facilities used in the provision of designated public transportation services, it shall be considered discrimination, for purposes of section 12132 of this title and section 794 of Title 29, for a public entity to fail to operate a designated public transportation program or activity conducted in such facilities so that, when viewed in the entirety, the program or activity is readily accessible to and usable by individuals with disabilities.

**(2) Exception**

Paragraph (1) shall not require a public entity to make structural changes to existing facilities in order to make such facilities accessible to individuals who use wheelchairs, unless and to the extent required by section 12147(a) of this title (relating to alterations) or section 12147(b) of this title (relating to key stations).

**(3) Utilization**

Paragraph (1) shall not require a public entity to which paragraph (2) applies, to provide to individuals who use wheelchairs services made available to the general public at such facilities when such individuals could not utilize or benefit from such services provided at such facilities.

**(b) One car per train rule**

**(1) General rule**

Subject to paragraph (2), with respect to 2 or more vehicles operated as a train by a light or rapid rail system,

for purposes of section 12132 of this title and section 794 of Title 29, it shall be considered discrimination for a public entity to fail to have at least 1 vehicle per train that is accessible to individuals with disabilities, including individuals who use wheelchairs, as soon as practicable but in no event later than the last day of the 5-year period beginning on the effective date of this section.

**(2) Historic trains**

In order to comply with paragraph (1) with respect to the remanufacture of a vehicle of historic character which is to be used on a segment of a light or rapid rail system which is included on the National Register of Historic Places, if making such vehicle readily accessible to and usable by individuals with disabilities would significantly alter the historic character of such vehicle, the public entity which operates such system only has to make (or to purchase or lease a remanufactured vehicle with) those modifications which are necessary to meet the requirements of section 12142(c)(1) of this title and which do not significantly alter the historic character of such vehicle.

**§ 12149. Regulations**

**(a) In general**

Not later than 1 year after July 26, 1990, the Secretary of Transportation shall issue regulations, in an accessible format, necessary for carrying out this subpart (other than section 12143 of this title).

**(b) Standards**

The regulations issued under this section and section 12143 of this title shall include standards applicable to facilities and vehicles covered by this part. The standards shall be consistent with the minimum guidelines and requirements issued by the Architectural and Transportation Barriers



Compliance Board in accordance with section 12204 of this title.

**§ 12150. Interim accessibility requirements**

If final regulations have not been issued pursuant to section 12149 of this title, for new construction or alterations for which a valid and appropriate State or local building permit is obtained prior to the issuance of final regulations under such section, and for which the construction or alteration authorized by such permit begins within one year of the receipt of such permit and is completed under the terms of such permit, compliance with the Uniform Federal Accessibility Standards in effect at the time the building permit is issued shall suffice to satisfy the requirement that facilities be readily accessible to and usable by persons with disabilities as required under sections 12146 and 12147 of this title, except that, if such final regulations have not been issued one year after the Architectural and Transportation Barriers Compliance Board has issued the supplemental minimum guidelines required under section 12204(a) of this title, compliance with such supplemental minimum guidelines shall be necessary to satisfy the requirement that facilities be readily accessible to and usable by persons with disabilities prior to issuance of the final regulations.

* * * * *

**§ 12161. Definitions**

As used in this subpart:

**(1) Commuter authority**

The term "commuter authority" has the meaning given such term in section 502(8) of Title 45.

**(2) Commuter rail transportation**

The term "commuter rail transportation" has the meaning given the term "commuter rail passenger transportation" in section 502(9) of Title 45.

**(3) Intercity rail transportation**

The term "intercity rail transportation" means transportation provided by the National Railroad Passenger Corporation.

**(4) Rail passenger car**

The term "rail passenger car" means, with respect to intercity rail transportation, single-level and bi-level coach cars, single-level and bi-level dining cars, single-level and bi-level sleeping cars, single-level and bi-level lounge cars, and food service cars.

**(5) Responsible person**

The term "responsible person" means—

(A) in the case of a station more than 50 percent of which is owned by a public entity, such public entity;

(B) in the case of a station more than 50 percent of which is owned by a private party, the persons providing intercity or commuter rail transportation to such station, as allocated on an equitable basis by regulation by the Secretary of Transportation; and

(C) in a case where no party owns more than 50 percent of a station, the persons providing intercity or commuter rail transportation to such station and the owners of the station, other than private party owners, as allocated on an equitable basis by regulation by the Secretary of Transportation.



**(6) Station**

The term "station" means the portion of a property located appurtenant to a right-of-way on which intercity or commuter rail transportation is operated, where such portion is used by the general public and is related to the provision of such transportation, including passenger platforms, designated waiting areas, ticketing areas, restrooms, and, where a public entity providing rail transportation owns the property, concession areas, to the extent that such public entity exercises control over the selection, design, construction, or alteration of the property, but such term does not include flag stops.

## § 12162. Intercity and commuter rail actions considered discriminatory

**(a) Intercity rail transportation**

**(1) One car per train rule**

It shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a person who provides intercity rail transportation to fail to have at least one passenger car per train that is readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, in accordance with regulations issued under section 12164 of this title, as soon as practicable, but in no event later than 5 years after July 26, 1990.

**(2) New intercity cars**

**(A) General rule**

Except as otherwise provided in this subsection with respect to individuals who use wheelchairs, it shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a

person to purchase or lease any new rail passenger cars for use in intercity rail transportation, and for which a solicitation is made later than 30 days after July 26, 1990, unless all such rail cars are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, as prescribed by the Secretary of Transportation in regulations issued under section 12164 of this title.

**(B) Special rule for single-level passenger coaches for individuals who use wheelchairs**

Single-level passenger coaches shall be required to—

(i) be able to be entered by an individual who uses a wheelchair;

(ii) have space to park and secure a wheelchair;

(iii) have a seat to which a passenger in a wheelchair can transfer, and a space to fold and store such passenger's wheelchair; and

(iv) have a restroom usable by an individual who uses a wheelchair,

only to the extent provided in paragraph (3).

**(C) Special rule for single-level dining cars for individuals who use wheelchairs**

Single-level dining cars shall not be required to—

(i) be able to be entered from the station platform by an individual who uses a wheelchair; or

(ii) have a restroom usable by an individual who uses a wheelchair if no restroom is provided in such car for any passenger.



**(D) Special rule for bi-level dining cars for individuals who use wheelchairs**

Bi-level dining cars shall not be required to—

(i) be able to be entered by an individual who uses a wheelchair;

(ii) have space to park and secure a wheelchair;

(iii) have a seat to which a passenger in a wheelchair can transfer, or a space to fold and store such passenger's wheelchair; or

(iv) have a restroom usable by an individual who uses a wheelchair.

**(3) Accessibility of single-level coaches**

**(A) General rule**

It shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a person who provides intercity rail transportation to fail to have on each train which includes one or more single-level rail passenger coaches—

(i) a number of spaces—

(I) to park and secure wheelchairs (to accommodate individuals who wish to remain in their wheelchairs) equal to not less than one-half of the number of single-level rail passenger coaches in such train; and

(II) to fold and store wheelchairs (to accommodate individuals who wish to transfer to coach seats) equal to not less than one-half of the number of single-level rail passenger coaches in such train,

as soon as practicable, but in no event later than 5 years after July 26, 1990; and

(ii) a number of spaces—

(I) to park and secure wheelchairs (to accommodate individuals who wish to remain in their wheelchairs) equal to not less than the total number of single-level rail passenger coaches in such train; and

(II) to fold and store wheelchairs (to accommodate individuals who wish to transfer to coach seats) equal to not less than the total number of single-level rail passenger coaches in such train,

as soon as practicable, but in no event later than 10 years after July 26, 1990.

**(B) Location**

Spaces required by subparagraph (A) shall be located in single-level rail passenger coaches or food service cars.

**(C) Limitation**

Of the number of spaces required on a train by subparagraph (A), not more than two spaces to park and secure wheelchairs nor more than two spaces to fold and store wheelchairs shall be located in any one coach or food service car.

**(D) Other accessibility features**

Single-level rail passenger coaches and food service cars on which the spaces required by subparagraph (A) are located shall have a restroom usable by an individual who uses a wheelchair and shall be able to



be entered from the station platform by an individual who uses a wheelchair.

**(4) Food service**

**(A) Single-level dining cars**

On any train in which a single-level dining car is used to provide food service—

(i) if such single-level dining car was purchased after July 26, 1990, table service in such car shall be provided to a passenger who uses a wheelchair if—

(I) the car adjacent to the end of the dining car through which a wheelchair may enter is itself accessible to a wheelchair;

(II) such passenger can exit to the platform from the car such passenger occupies, move down the platform, and enter the adjacent accessible car described in subclause (I) without the necessity of the train being moved within the station; and

(III) space to park and secure a wheelchair is available in the dining car at the time such passenger wishes to eat (if such passenger wishes to remain in a wheelchair), or space to store and fold a wheelchair is available in the dining car at the time such passenger wishes to eat (if such passenger wishes to transfer to a dining car seat); and

(ii) appropriate auxiliary aids and services, including a hard surface on which to eat, shall be provided to ensure that other equivalent food service is available to individuals with disabilities, including individuals who use wheelchairs, and to passengers traveling with such individuals.

Unless not practicable, a person providing intercity rail transportation shall place an accessible car adjacent to the end of a dining car described in clause (i) through which an individual who uses a wheelchair may enter.

**(B) Bi-level dining cars**

On any train in which a bi-level dining car is used to provide food service—

(i) if such train includes a bi-level lounge car purchased after July 26, 1990, table service in such lounge car shall be provided to individuals who use wheelchairs and to other passengers; and

(ii) appropriate auxiliary aids and services, including a hard surface on which to eat, shall be provided to ensure that other equivalent food service is available to individuals with disabilities, including individuals who use wheelchairs, and to passengers traveling with such individuals.

**(b) Commuter rail transportation**

**(1) One car per train rule**

It shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a person who provides commuter rail transportation to fail to have at least one passenger car per train that is readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, in accordance with regulations issued under section 12164 of this title, as soon as practicable, but in no event later than 5 years after July 26, 1990.



**(2) New commuter rail cars**

**(A) General rule**

It shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a person to purchase or lease any new rail passenger cars for use in commuter rail transportation, and for which a solicitation is made later than 30 days after July 26, 1990, unless all such rail cars are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, as prescribed by the Secretary of Transportation in regulations issued under section 12164 of this title.

**(B) Accessibility**

For purposes of section 12132 of this title and section 794 of Title 29, a requirement that a rail passenger car used in commuter rail transportation be accessible to or readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, shall not be construed to require—

(i) a restroom usable by an individual who uses a wheelchair if no restroom is provided in such car for any passenger;

(ii) space to fold and store a wheelchair; or

(iii) a seat to which a passenger who uses a wheelchair can transfer.

**(c) Used rail cars**

It shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29, for a person to purchase or lease a used rail passenger car for use in intercity or commuter rail transportation, unless such person makes demonstrated good faith efforts to purchase or lease a

used rail car that is readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, as prescribed by the Secretary of Transportation in regulations issued under section 12164 of this title.

**(d) Remanufactured rail cars**

**(1) Remanufacturing**

It shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a person to remanufacture a rail passenger car for use in intercity or commuter rail transportation so as to extend its usable life for 10 years or more, unless the rail car, to the maximum extent feasible, is made readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, as prescribed by the Secretary of Transportation in regulations issued under section 12164 of this title.

**(2) Purchase or lease**

It shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a person to purchase or lease a remanufactured rail passenger car for use in intercity or commuter rail transportation unless such car was remanufactured in accordance with paragraph (1).

**(e) Stations**

**(1) New stations**

It shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a person to build a new station for use in intercity or commuter rail transportation that is not readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, as prescribed by the Secre-



tary of Transportation in regulations issued under section 12164 of this title.

**(2) Existing stations**

**(A) Failure to make readily accessible**

**(i) General rule**

It shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for a responsible person to fail to make existing stations in the intercity rail transportation system, and existing key stations in commuter rail transportation systems, readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, as prescribed by the Secretary of Transportation in regulations issued under section 12164 of this title.

**(ii) Period for compliance**

**(I) Intercity rail**

All stations in the intercity rail transportation system shall be made readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, as soon as practicable, but in no event later than 20 years after July 26, 1990.

**(II) Commuter rail**

Key stations in commuter rail transportation systems shall be made readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, as soon as practicable but in no event later than 3 years after July 26, 1990, except that the time limit may be extended by the Secretary of

Transportation up to 20 years after July 26, 1990, in a case where the raising of the entire passenger platform is the only means available of attaining accessibility or where other extraordinarily expensive structural changes are necessary to attain accessibility.

**(iii) Designation of key stations**

Each commuter authority shall designate the key stations in its commuter rail transportation system, in consultation with individuals with disabilities and organizations representing such individuals, taking into consideration such factors as high ridership and whether such station serves as a transfer or feeder station. Before the final designation of key stations under this clause, a commuter authority shall hold a public hearing.

**(iv) Plans and milestones**

The Secretary of Transportation shall require the appropriate person to develop a plan for carrying out this subparagraph that reflects consultation with individuals with disabilities affected by such plan and that establishes milestones for achievement of the requirements of this subparagraph.

**(B) Requirement when making alterations**

**(i) General rule**

It shall be considered discrimination, for purposes of section 12132 of this title and section 794 of Title 29, with respect to alterations of an existing station or part thereof in the intercity or commuter rail transportation systems that affect or could affect the usability of the station or part



thereof, for the responsible person, owner, or person in control of the station to fail to make the alterations in such a manner that, to the maximum extent feasible, the altered portions of the station are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, upon completion of such alterations.

**(ii) Alterations to a primary function area**

It shall be considered discrimination, for purposes of section 12132 of this title and section 794 of Title 29, with respect to alterations that affect or could affect the usability of or access to an area of the station containing a primary function, for the responsible person, owner, or person in control of the station to fail to make the alterations in such a manner that, to the maximum extent feasible, the path of travel to the altered area, and the bathrooms, telephones, and drinking fountains serving the altered area, are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, upon completion of such alterations, where such alterations to the path of travel or the bathrooms, telephones, and drinking fountains serving the altered area are not disproportionate to the overall alterations in terms of cost and scope (as determined under criteria established by the Attorney General).

**(C) Required cooperation**

It shall be considered discrimination for purposes of section 12132 of this title and section 794 of Title 29 for an owner, or person in control, of a station governed by subparagraph (A) or (B) to fail to provide reasonable cooperation to a responsible person with

respect to such station in that responsible person's efforts to comply with such subparagraph. An owner, or person in control, of a station shall be liable to a responsible person for any failure to provide reasonable cooperation as required by this subparagraph. Failure to receive reasonable cooperation required by this subparagraph shall not be a defense to a claim of discrimination under this chapter.

### § 12163. Conformance of accessibility standards

Accessibility standards included in regulations issued under this subpart shall be consistent with the minimum guidelines issued by the Architectural and Transportation Barriers Compliance Board under section 12204(a) of this title.

### § 12164. Regulations

Not later than 1 year after July 26, 1990, the Secretary of Transportation shall issue regulations, in an accessible format, necessary for carrying out this subpart.

### § 12165. Interim accessibility requirements

#### (a) Stations

If final regulations have not been issued pursuant to section 12164 of this title, for new construction or alterations for which a valid and appropriate State or local building permit is obtained prior to the issuance of final regulations under such section, and for which the construction or alteration authorized by such permit begins within one year of the receipt of such permit and is completed under the terms of such permit, compliance with the Uniform Federal Accessibility Standards in effect at the time the building permit is issued shall suffice to satisfy the requirement that stations be readily accessible to and usable by persons with disabili-



ties as required under section 12162(e) of this title, except that, if such final regulations have not been issued one year after the Architectural and Transportation Barriers Compliance Board has issued the supplemental minimum guidelines required under section 12204(a) of this title, compliance with such supplemental minimum guidelines shall be necessary to satisfy the requirement that stations be readily accessible to and usable by persons with disabilities prior to issuance of the final regulations.

#### (b) Rail passenger cars

If final regulations have not been issued pursuant to section 12164 of this title, a person shall be considered to have complied with the requirements of section 12162(a) through (d) of this title that a rail passenger car be readily accessible to and usable by individuals with disabilities, if the design for such car complies with the laws and regulations (including the Minimum Guidelines and Requirements for Accessible Design and such supplemental minimum guidelines as are issued under section 12204(a) of this title) governing accessibility of such cars, to the extent that such laws and regulations are not inconsistent with this subpart and are in effect at the time such design is substantially completed.

## Title IV of The Americans With Disabilities Act

### § 12201. Construction

#### (a) In general

Except as otherwise provided in this chapter, nothing in this chapter shall be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973 (29 U.S.C. 790 et seq.) or the regulations issued by Federal agencies pursuant to such title.

#### (b) Relationship to other laws

Nothing in this chapter shall be construed to invalidate or limit the remedies, rights, and procedures of any Federal law or law of any State or political subdivision of any State or jurisdiction that provides greater or equal protection for the rights of individuals with disabilities than are afforded by this chapter. Nothing in this chapter shall be construed to preclude the prohibition of, or the imposition of restrictions on, smoking in places of employment covered by subchapter I of this chapter, in transportation covered by subchapter II or III of this chapter, or in places of public accommodation covered by subchapter III of this chapter.

#### (c) Insurance

Subchapters I through III of this chapter and title IV of this Act shall not be construed to prohibit or restrict—

(1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or



(2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapter[2] I and III of this chapter.

#### (d) Accommodations and services

Nothing in this chapter shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit which such individual chooses not to accept.

### § 12202. State immunity

A State shall not be immune under the eleventh amendment to the Constitution of the United States from an action in[3] Federal or State court of competent jurisdiction for a violation of this chapter. In any action against a State for a violation of the requirements of this chapter, remedies (including remedies both at law and in equity) are available for such a violation to the same extent as such remedies are available for such a violation in an action against any public or private entity other than a State.

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[2] So in original. Probably should be "subchapters".

[3] So in original. Probably should be "in a".

### § 12203. Prohibition against retaliation and coercion

#### (a) Retaliation

No person shall discriminate against any individual because such individual has opposed any act or practice made unlawful by this chapter or because such individual made a charge, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under this chapter.

#### (b) Interference, coercion, or intimidation

It shall be unlawful to coerce, intimidate, threaten, or interfere with any individual in the exercise or enjoyment of, or on account of his or her having exercised or enjoyed, or on account of his or her having aided or encouraged any other individual in the exercise or enjoyment of, any right granted or protected by this chapter.

#### (c) Remedies and procedures

The remedies and procedures available under sections 12117, 12133, and 12188 of this title shall be available to aggrieved persons for violations of subsections (a) and (b) of this section, with respect to subchapter I, subchapter II and subchapter III of this chapter, respectively.

### § 12204. Regulations by Architectural and Transportation Barriers Compliance Board

#### (a) Issuance of guidelines

Not later than 9 months after July 26, 1990, the Architectural and Transportation Barriers Compliance Board shall issue minimum guidelines that shall supplement the existing Minimum Guidelines and Requirements for Accessible



Design for purposes of subchapters II and III of this chapter.

#### (b) Contents of guidelines

The supplemental guidelines issued under subsection (a) of this section shall establish additional requirements, consistent with this chapter, to ensure that buildings, facilities, rail passenger cars, and vehicles are accessible, in terms of architecture and design, transportation, and communication, to individuals with disabilities.

#### (c) Qualified historic properties

##### (1) In general

The supplemental guidelines issued under subsection (a) of this section shall include procedures and requirements for alterations that will threaten or destroy the historic significance of qualified historic buildings and facilities as defined in 4.1.7(1)(a) of the Uniform Federal Accessibility Standards.

##### (2) Sites eligible for listing in National Register

With respect to alterations of buildings or facilities that are eligible for listing in the National Register of Historic Places under the National Historic Preservation Act (16 U.S.C. 470 et seq.), the guidelines described in paragraph (1) shall, at a minimum, maintain the procedures and requirements established in 4.1.7(1) and (2) of the Uniform Federal Accessibility Standards.

**(3) Other sites**

With respect to alterations of buildings or facilities designated as historic under State or local law, the guidelines described in paragraph (1) shall establish procedures equivalent to those established by 4.1.7(1)(b) and (c) of the Uniform Federal Accessibility Standards, and shall require, at a minimum, compliance with the requirements established in 4.1.7(2) of such standards.

## § 12205. Attorney's fees

In any action or administrative proceeding commenced pursuant to this chapter, the court or agency, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee, including litigation expenses, and costs, and the United States shall be liable for the foregoing the same as a private individual.

## § 12206. Technical assistance

**(c) Plan for assistance**

**(1) In general**

Not later than 180 days after July 26, 1990, the Attorney General, in consultation with the Chair of the Equal Employment Opportunity Commission, the Secretary of Transportation, the Chair of the Architectural and Transportation Barriers Compliance Board, and the Chairman of the Federal Communications Commission, shall develop a plan to assist entities covered under this chapter, and other Federal agencies, in understanding the responsibility of such entities and agencies under this chapter.



**(2) Publication of plan**

The Attorney General shall publish the plan referred to in paragraph (1) for public comment in accordance with subchapter II of chapter 5 of title 5 (commonly known as the Administrative Procedure Act).

**(b) Agency and public assistance**

The Attorney General may obtain the assistance of other Federal agencies in carrying out subsection (a) of this section, including the National Council on Disability, the President's Committee on Employment of People with Disabilities, the Small Business Administration, and the Department of Commerce.

**(c) Implementation**

**(1) Rendering assistance**

Each Federal agency that has responsibility under paragraph (2) for implementing this chapter may render technical assistance to individuals and institutions that have rights or duties under the respective subchapter or subchapters of this chapter for which such agency has responsibility.

**(2) Implementation of subchapters**

**(A) Subchapter I**

The Equal Employment Opportunity Commission and the Attorney General shall implement the plan for assistance developed under subsection (a) of this section, for subchapter I of this chapter.

**(B) Subchapter II**

**(i) Part A**

The Attorney General shall implement such plan for assistance for part A of subchapter II of this chapter.

**(ii) Part B**

The Secretary of Transportation shall implement such plan for assistance for part B subchapter II of this chapter.

**(C) Subchapter III**

The Attorney General, in coordination with Secretary of Transportation and the Chair of the Architectural Transportation Barriers Compliance Board, shall implement such plan for assistance for subchapter III of this chapter, except for section 12184 of this title, the plan for assistance for which shall be implemented by the Secretary of Transportation.

**(D) Title IV**

The Chairman of the Federal Communications Commission, in coordinate with the Attorney General, shall implement such plan for assistance for title IV.

**(3) Technical assistance manuals**

Each Federal agency that has responsibility under paragraph (2) for implementing this chapter shall, as part of its implementation responsibilities, ensure the availability and provision of appropriate technical assistance manuals to individuals or entities with rights or duties under this chapter no later than six months after applicable final regulations are published under subchapters I, II, and III of this chapter and title IV.



**(d) Grants and contracts**

**(1) In general**

Each Federal agency that has responsibility under subsection (c)(2) of this section for implementing this chapter may make grants or award contracts to effectuate the purposes of this section, subject to the availability of appropriations. Such grants and contracts may be awarded to individuals, institutions not organized for profit and no part of the net earnings of which inures to the benefit or any private shareholder or individual (including educational institutions), and associations representing individuals who have rights or duties under this chapter. Contracts may be awarded to entities organized for profit, but such entities may not be the recipients or[1] grants described in this paragraph.

**(2) Dissemination of information**

Such grants and contracts, among other uses, may be designed to ensure wide dissemination of information about the rights and duties established by this chapter and to provide information and technical assistance about techniques for effective compliance with this chapter.

**(e) Failure to receive assistance**

An employer, public accommodation, or other entity covered under this chapter shall not be excused from compliance with the requirements of this chapter because of any failure to receive technical assistance under this section,

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[1] So in original. Probably should be "of".

including any failure in the development or dissemination of any technical assistance manual authorized by this section.

### § 12207. Federal wilderness areas

#### (a) Study

The National Council on Disability shall conduct a study and report on the effect that wilderness designations and wilderness land management practices have on the ability of individuals with disabilities to use and enjoy the National Wilderness Preservation System as established under the Wilderness Act (16 U.S.C. 1131 *et seq.*).

#### (b) Submission of report

Not later than 1 year after July 26, 1990, the National Council on Disability shall submit the report required under subsection (a) of this section to Congress.

#### (c) Specific wilderness access

##### (1) In general

Congress reaffirms that nothing in the Wilderness Act [16 U.S.C. 1131 et seq.] is to be construed as prohibiting the use of a wheelchair in a wilderness area by an individual whose disability requires use of a wheelchair, and consistent with the Wilderness Act no agency is required to provide any form of special treatment or accommodation, or to construct any facilities or modify any conditions of lands within a wilderness area in order to facilitate such use.

##### (2) "Wheelchair" defined

For purposes of paragraph (1), the term "wheelchair" means a device designed solely for use by a mobility-



impaired person for locomotion, that is suitable for use in an indoor pedestrian area.

### § 12208. Transvestites

For the purposes of this chapter, the term "disabled" or "disability" shall not apply to an individual solely because that individual is a transvestite.

### § 12209. Instrumentalities of the Congress

The General Accounting Office, the Government Printing Office, and the Library of Congress shall be covered as follows:

#### (1) In general

The rights and protections under this chapter shall, subject to paragraph (2), apply with respect to the conduct of each instrumentality of the Congress.

#### (2) Establishment of remedies and procedures by instrumentalities

The chief official of each instrumentality of the Congress shall establish remedies and procedures to be utilized with respect to the rights and protections provided pursuant to paragraph (1).

#### (3) Report to Congress

The chief official of each instrumentality of the Congress shall, after establishing remedies and procedures for purposes of paragraph (2), submit to the Congress a report describing the remedies and procedures.

**(4) Definition of instrumentality**

For purposes of this section, the term "instrumentality of the Congress" means the following:,[1] the General Accounting Office, the Government Printing Office, and the Library of Congress,.[1]

**(5) Enforcement of employment rights**

The remedies and procedures set forth in section 2000e-16 of this title shall be available to any employee of an instrumentality of the Congress who alleges a violation of the rights and protections under sections 12112 through 12114 of this title that are made applicable by this section, except that the authorities of the Equal Employment Opportunity Commission shall be exercised by the chief official of the instrumentality of the Congress.

**(6) Enforcement of rights to public services and accommodations**

The remedies and procedures set forth in section 2000e-16 of this title shall be available to any qualified person with a disability who is a visitor, guest, or patron of an instrumentality of Congress and who alleges a violation of the rights and protections under sections 12131 through 12150 or section 12182 or 12183 of this title that are made applicable by this section, except that the authorities of the Equal Employment Opportunity Commission shall be exercised by the chief official of the instrumentality of the Congress.

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1 So in original. The comma probably should not appear.



**(7) Construction**

Nothing in this section shall alter the enforcement procedures for individuals with disabilities provided in the General Accounting Office Personnel Act of 1980 and regulations promulgated pursuant to that Act.

**§ 12210. Illegal use of drugs**

**(a) In general**

For purposes of this chapter, the term "individual with a disability" does not include an individual who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use.

**(b) Rules of construction**

Nothing in subsection (a) of this section shall be construed to exclude as an individual with a disability an individual who—

**(1)** has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use;

**(2)** is participating in a supervised rehabilitation program and is no longer engaging in such use; or

**(3)** is erroneously regarded as engaging in such use, but is not engaging in such use; except that it shall not be a violation of this chapter for a covered entity to adopt or administer reasonable policies or procedures, including but not limited to drug testing, designed to ensure that an individual described in paragraph (1) or (2) is no longer engaging in the illegal use of drugs; however, nothing in

this section shall be construed to encourage, prohibit, restrict, or authorize the conducting of testing for the illegal use of drugs.

**(c) Health and other services**

Notwithstanding subsection (a) of this section and section 12211(b)(3) of this title, an individual shall not be denied health services, or services provided in connection with drug rehabilitation, on the basis of the current illegal use of drugs if the individual is otherwise entitled to such services.

**(d) "Illegal use of drugs" defined**

**(1) In general**

The term "illegal use of drugs" means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act [21 U.S.C. 801 et seq.]. Such term does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act [21 U.S.C. 801 et seq.] or other provisions of Federal law.

**(2) Drugs**

The term "drug" means a controlled substance, as defined in schedules I through V of section 202 of the Controlled Substances Act [21 U.S.C. 812].

**§ 12211. Definitions**

**(a) Homosexuality and bisexuality**

For purposes of the definition of "disability" in section 12102(2) of this title, homosexuality and bisexuality are not



impairments and as such are not disabilities under this chapter.

**(b) Certain conditions**

Under this chapter, the term "disability" shall not include—

**(1)** transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders;

**(2)** compulsive gambling, kleptomania, or pyromania; or

**(3)** psychoactive substance use disorders resulting from current illegal use of drugs.

**§ 12212. Alternative means of dispute resolution**

Where appropriate and to the extent authorized by law, the use of alternative means of dispute resolution, including settlement negotiations, conciliation, facilitation, mediation, factfinding, minitrials, and arbitration, is encouraged to resolve disputes arising under this chapter.

**§ 12213. Severability**

Should any provision in this chapter be found to be unconstitutional by a court of law, such provision shall be severed from the remainder of this chapter and such action shall not affect the enforceability of the remaining provisions of this chapter.